To: [Name of Health Plan or Provider]

Address: [Street Address, City, State, Zip Code]

Date: [Date]

Subject: Request for Confidential Communications

Dear Privacy Officer,

I am writing to formally request that you communicate my protected health information (PHI) to me by alternative means or at an alternative location. This request is made pursuant to my rights under the HIPAA Privacy Rule (45 CFR $ 164.522(b)).

Patient Information:
Name: [Full Name]
Date of Birth: [MM/DD/YYYY]
Member/Policy ID Number: [ID Number]

Reason for Request (Optional for Providers / Required for Health Plans if disclosure endangers the individual):
[Insert reason if applicable, e.g., "I believe that disclosure of all or part of this information could endanger me."]

Communication Instructions:
Please use the following contact information for all future communications regarding my health information, including bills, explanation of benefits (EOB) forms, and appointment reminders:

- **Mailing Address:** [Alternative Street Address, P.O. Box, City, State, Zip]
- **Phone Number:** [Alternative Phone Number]
- **Email Address:** [Alternative Email Address]

I understand that this request applies to all communications from your office/organization until I revoke it in writing. Please confirm in writing once this request has been processed.

Sincerely,

[Signature]

[Printed Name]