Duke University Health Plan Participant's Request for Information to be Transmitted by Alternative Means

Please complete this form and send it to: The Benefits Administration and Communication Manager, Duke University Benefits Office, Durham, NC 27705 or fax it to (919) 681-8774.

Participant Name: _____ Birth Date: ___ /_____/___

Address: _____

_____

Home Telephone Number: _____ E-mail: _____

Participant Identification Number and/or Social Security Number: _____ _____

I, _____, am requesting that the Health Plan communicate with me in the alternative manner and/or location described below regarding my health information (information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996). Such restriction is necessary to prevent a disclosure that could endanger me. I understand that the Health Plan may deny this request if it imposes an unreasonable administrative burden.

Description of the Health Information that Must be Communicated by Alternative Means. The following is a description of the specific health information to which this request applies:

_____

_____

Alternative Manner and/or Location. I request that Health Plan only communicate with me in the following manner and/or at the location described below:

_____

By signing this form, I am confirming that it accurately reflects my wishes.

_____ _____/_____/_____

Signature Date

If signed by personal representative:
Name of personal representative: _____

Relationship to participant or nature of authority: _____

_____ _____/_____/_____

Signature of Personal Representative Date