



Confidential Communication Request Form

If you could be at risk of harm, harassment, or abuse when your protected health information (PHI) is shared, you have the right to request CEC restrict how PHI about you is used or disclosed, or that it be sent directly to you at an alternate address. Restrictions do not apply to emergency treatment or services when use or disclosure without your written permission is authorized or required by law.

Section I – Member Requesting Restriction of Use or Disclosure of Protected Health Information				
First Name:	Middle Name/Initial:	Last Name:		
Mailing Address/PO Box:	City:	State:	Zip Code:	
Member ID#:		Date of Birth (MM/DD/YYYY):		
Email:	Mobile Phone:	Daytime Phone:		

Section II – Purpose of Request (Select all that apply)			
<p>A. Confidential Communications</p> <p>I request CEC send claim-related information by alternative means or to an alternative location. Checking this box means CEC will use reasonable efforts to mail correspondence containing PHI to the alternative address.</p> <ol style="list-style-type: none"> 1. CEC mails communications containing PHI to the address maintained in our system for the individual. We may rely on if claims submission form providers to generate correspondence. CEC will use reasonable efforts to mail correspondence containing PHI to the address you specify on this form. 2. This request will not affect the current residential or mailing address listed in provider or facility systems of records. 3. If you move or otherwise need to change the alternative address, you will need to submit a new form to CEC. 4. If approved, the alternative address may be shown on correspondence about you that CEC sends to others, such as your provider, or upon request of an authorized representative. 			
Alternative Address:	City:	State:	Zip Code:
Alternative Phone (optional):			

<p>B. I request PHI to be restricted.</p> <p>Specify the PHI or specific episode of care you want to be handled in a restricted manner and provide the name(s) of the person(s) you would like the information to be restricted from.</p>
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<p>C. I wish to revoke my previously submitted request for restriction.</p>
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Section III – Signature

I have read and understand the information on this request.

1. CEC is not required to approve this request for restriction/confidential communications.
2. If your form is incomplete, you will be notified by mail or telephone and your request will not be considered until a completed form is received, or the missing information is provided.
3. Approved requests apply only to the records maintained by CEC or our business associates. It is not transferable to other providers/facilities, health plans, or other persons or entities outside of CEC; you must obtain their agreement to a restriction separately.
4. CEC is not permitted to restrict access to either parent regardless of custody, unless a court order allows for such an action, or both parents have signed the form. This ensures that both parents are aware of and approve the restriction.
5. While approved restrictions do not prevent you from having access to your own health information or to an accounting of how your health information has been used, access to the online member portal may no longer be available. Access must be requested from CEC by telephone or in writing
6. Once approved, this restriction can be terminated under the following circumstances:
 - a. A. Upon expiration.
 - b. You request the termination in writing.
 - c. If CEC informs you that it has decided to terminate the restriction. In this situation, the termination only applies to the health information created or received after the termination is in effect.
7. If CEC denies your request, you will be notified of our decision.

Signature(s) of Individual(s)* or Personal Representative(s)**:	Date (MM/DD/YYYY):
Printed Name(s) of Individual(s)* or Personal Representative(s)**:	Expiration Date (MM/DD/YYYY):

* If you are a parent or guardian requesting a restriction on a child that will prevent the child’s other parent from accessing or receiving the child’s PHI, you must:

- Provide legal documentation showing parental rights of the other parent have been terminated, or access to the child’s PHI is prohibited by law.

OR

- Obtain the other parent’s agreement to this restriction. If you obtain the other parent’s agreement to this restriction, please provide both signatures on this form or include a statement signed by both parents indicating both parents agree to place a restriction on the child’s PHI.

<p>** If this request is by a personal representative on behalf of the beneficiary, check the box on the right that describes the relationship to the member and attach documentation of the representative’s authority.</p>	<p>Parent of Minor Child Legal Guardian Power of Attorney Executor Other (please explain) _____</p>
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Please make a copy of your signed request before sending it to CEC. return this completed form and any related documentation to: **Community Eye Care (CEC), Attn: Privacy Requests, 4944 Parkway Plaza Blvd, Suite 200, Charlotte, NC 28217** or email to **info@cecvision.com**.

CEC USE ONLY	
<p>We have approved the requested restriction.</p> <p>We were unable to approve the following restriction you have requested:</p> <p style="padding-left: 20px;">Incomplete form</p> <p style="padding-left: 20px;">Legal documents required</p> <p style="padding-left: 20px;">Signature(s) required</p> <p>Initials _____ Date _____</p>	<p>Denied:</p> <p style="padding-left: 20px;">Invalid legal documents</p> <p style="padding-left: 20px;">Legal documents not available</p> <p style="padding-left: 20px;">Unable to accommodate request</p> <p>CEC has terminated the restriction effective _____</p> <p>Initials _____ Date _____</p>

This document may contain information covered under HIPAA and its various implementing regulations and must be protected in accordance with those provisions. If you have received this correspondence in error, please notify CEC immediately, then destroy the document and any copies you have made.