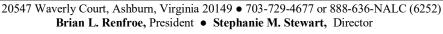
CONSUMER DRIVEN HEALTH PLAN



Coation A shout the subject of the DIII (Detient)

NATIONAL ASSOCIATION OF LETTER CARRIERS

HEALTH BENEFIT PLAN





Request to Receive PHI at an Alternative Address

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule, you have the right to request confidential communications of protected health information (PHI), if you believe disclosure of the information could result in harm to yourself or to others. Communication will be made by first class mail through the U.S. Postal Service. Please complete this form to make your request.

Section A - about the subj	ect of the Phi (Patient)		
Member #	Patient's full name		
Patient's date of birth	Daytime p	ohone ()	
Patient's relationship to the (Examp	e enrollee bles: self, spouse, son, daughte	r, stepchild, foster ch	ild)
Section B - about you and	your request (Please print)		
Your name			
Your relationship to the particle (Examp	tient bles: self, spouse, parent, child,	personal representa	tive)
Alternative mailing address	S		
City	State	Zip	
	my/the patient's protected healing that the NALC Consumer D		
Signature		Date	