Confidential Communications Revocation Request Form

I want to cancel or revoke the Confidential Communication Request I gave to Health Net, LLC. with regards to:

- Communication (messaging, alerts, etc.) of account
- Medical information
- Sensitive services

This is to take effect on the date listed below.

Your information:		
First name:	Last name:	Birthdate:
Subscriber ID number:	Phone number: *Where to call you if we have questions?*	
Mailing address:		
City:	State:	ZIP:
Email address:		

California law states: "Sensitive Services means: all health care services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender affirming care, and intimate partner violence."

Health information includes:

- Explanation of Benefits (EOB) alerts and information about your appointments.
- Claim denials. Requests for more information about claims. Alerts about contested claims.
- The name and address of your provider. Details of services performed and other visit information.

I know that my health information may have been sent to the preferred backup line of communication.
I also know that this repeal only applies to the consent that I asked for prior to the backup communication.

I attest and acknowledge that the above information is true and correct.	
Signature:	Date:

(continued)

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If you are signing for the member, describe your relationship below. If you are the member's personal representative, describe this below. And, send us copies of those forms (such as Power of Attorney or Order of Guardianship).

I attest and acknowledge that the above information is true and correct.	
Personal representative name: (Please print)	
Please describe the relationship:	
Relationship to the member: (Please print)	
Personal representative signature:	
Signature:	Date:

Health Net will stop using or sharing your health information when we receive and process this form. Use the mailing address below. You can also call for help at the number below.

Please mail or fax this finished form to Health Net. Allow up to 14 days for us to process your request.

Mail: Health Net – Privacy Office
PO Box 9103, Van Nuys, CA 91409-9103

Fax: (818) 676-8314, Attention: Health Net Privacy Office

Tip!

If you change your enrollment to another plan, you will need to complete this form again under your new member ID Number.

We're here to help!

Please call or email us if you have questions.

Phone: Refer to the phone number on the back on your member ID card.

Email: Privacy@HealthNet.com

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