Confidential Communications Revocation Request Form

I want to cancel or revoke the Confidential Communication Request I gave to Managed Health Network (MHN) with regards to communication (messaging, notices, etc.) of Sensitive Services with PHI. This is to take effect on the date given below.

California law states: "'Sensitive Services' means all health care services related to mental or behavioral health … [or] substance use disorder...obtained by a patient at or above the minimum age specified for consenting to the service…." There are also other Sensitive Services that are covered by medical/surgical health insurance and not by MHN.

Protected Health Information ("PHI") includes:

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

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

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:

MHN will stop sending your Confidential Communications to the mailing address or email that you previously designated, and will resume sending them to the mailing address or email on file for the subscriber.

Please mail or email this finished form to MHN.

Allow up to 7 days for emailed requests and 14 days after receipt of mailed requests for processing.

Mail: MHN NSU
P.O. Box 10697
San Rafael, CA 94912

Email: AuthorizationforDisclosure@healthnet.com

We're here to help!
Please call if you have questions.

Phone: Call the phone number on your member ID card or 1 888-327-0010

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