INDIVIDUAL REQUEST FOR CONFIDENTIAL COMMUNICATION OF PROTECTED HEALTH INFORMATION

I understand that the Loyola University New Orleans Employee Benefit Plan ("Health Plan") may use and disclose **protected health information about me for purposes of health care treatment, payment and health care operations without my consent.** I request that communications regarding my "Protected Health Information," more specifically described as follows:

_____

_____

be communicated in a confidential manner.

Termination of Confidential Communication: I understand that if the Health Plan agrees to my request for Confidential Communication, either the Plan or I may terminate this restriction at any time. The termination of the restriction is only effective for future uses and disclosures occurring after the Plan receives this request.

Questionnaire: Please complete all of the following questions. If the question is not applicable, mark N/A on the answer line.

(1) I request that the PHI described above be communicated to me at the following address/location:

_____

_____

_____

(2) I request that the PHI described above be communicated to me in the following manner [description of restriction]:

_____

_____

I understand that if a reasonable request for confidential communication is not made and is not specifically listed above and agreed to in writing by the Health Plan, it will not be effective.

Signature: _____ Date: _____

Date of Receipt by Plan: _____

Please mail or fax the completed Form to: Donna Rochon, Privacy Officer for the Loyola University New Orleans Employee Benefit Plan, Human Resources Department, Loyola University New Orleans, 6363 St. Charles Avenue, Campus Box 16, New Orleans, LA 70118, 504.864.7272 (phone), 504.864.7100 (fax).