Confidential Communications Request

TO:	Privacy Officer, America's Best Vision Plan 1202 Monte Vista Avenue, Suite 17, Upland, CA 91786
FRO]	ſ:
1110.	Your Name
Your	Date of Birth Your Member #
I am c	ntacting you to request that all medical information related to sensitive services I receive
arrang	d by America's Best Vision Plan including where and when I receive health care be sent
directl	to me and not to my family members. ("Sensitive services" include sexual and
reprod	ctive health care, mental health, sexual assault counseling and care and treatment for
alcoho	and drug use.)
I rean	st that communications containing any of the above information be sent to me as
Your Date of Birth	
,	
	• • • • • • • • • • • • • • • • • • • •
	United (please describe).
	IMPORTANT! The following two sections MUST be completed:
1.	and/or I prefer receiving information by U.S. mail, please use
2.	Is there a phone number or email we can use to contact you if we have questions regarding this request?
This	request is valid until I submit a revocation or a new request.
Signa	ure: Date: