Pacific Gas and Electric Company

Request for Confidential Communications of Personal Health Plan Information

Form Received By	Date

If you think that disclosure of your protected health information (PHI) by the usual means could endanger you in some way, the Pacific Gas and Electric Company Health Care Plan for Active Employees, The Pacific Gas and Electric Company Health Care Plan for Retirees and Surviving Dependents, and Pacific Gas and Electric Company Health Care Flexible Spending Account Plan (collectively, "Health Plan") will accommodate reasonable requests to receive communications of PHI from the Health Plan by alternative means or at alternative locations. If the Payment of benefits is affected by this request, the Health Plan may also deny this request unless you contact the PG&E HIPAA Administrator to discuss alternative Payment means.

1. Employee/Retiree Name	**1a. Employee/Retiree PERNO**
1b. Employee/Retiree Date of Birth	
2. Name of Person Whose Records You Are Requesting	**2a. Relationship to Employee** Self ☐ Spouse ☐ Child ☐ Other ☐
3. Your Name	**3a. Your Relationship to Person in Box 2** Self ☐ Spouse ☐ Parent ☐ Child ☐ ☐**Other (please describe relationship):**
4. Mailing Address for Records	**4a. City, State, Zip Code**

I am requesting that communication of PHI in personal health plan information for the person in Box 2 be provided by alternative means or at alternative locations. I **[check one (1)] [☐ am ☐ am not**] making this request because disclosure of all or part of the information to which the request pertains could endanger me, or the person I represent.

Please send the information by the following alternative means:

Please send the information to the following alternative address, if different than address above:

Street address ______________________

City, State and ZIP ______________________

Phone ______________________

Other ______________________

If this request relates to communication regarding Payment for health care services, please indicate how we can reach you to discuss alternative Payment means.

Signature **Date**

Please return completed form to: PG&E HIPAA Administrator, PG&E Benefits Department, 245 Market St., Mailcode N2T, San Francisco, CA 94105