DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-13156 (08/2020)

STATE OF WISCONSIN
P.L. 104-191

WISCONSIN CHRONIC DISEASE PROGRAM (WCDP)

HIPAA PRIVACY ALTERNATE COMMUNICATION REQUEST

The Privacy Rule standards of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) P.L. 104-191 require DHS, as a covered entity, to implement processes that give patients certain rights regarding individually identifiable health information. The information requested on this form is needed to comply with those Privacy Rule requirements.

Provision of the information that is requested on this form is voluntary. Although the use of this version of the form is voluntary, all of the information outlined on this form is mandatory.

Personally identifiable information requested on this form is mandatory in order to process your request and will only be used for this purpose.

INSTRUCTIONS: Mail this completed form to the following address:

WCDP
Member Services
PO Box 6410
Madison WI 53716

SECTION I – MEMBER INFORMATION	
Name – Last, First, Middle Initial	WCDP Identification Number
Address – Street, City, State, ZIP Code	Phone Number ( )

SECTION II – ALTERNATIVE COMMUNICATION REQUEST

Please read the following and complete the information requested.

You have the right to request how and where WCDP contacts you about your medical information. The Wisconsin Chronic Disease Program (WCDP) will accommodate reasonable requests if you provide a reasonable alternative means or location for communicating with you. To exercise this right, please complete this form. **NOTE**: **The WCDP does not routinely communicate protected health information to members, since the WCDP does not provide the health care or treatment directly to you.**

Describe the protected health information you want subjected to alternative communication:

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☐ I request that the WCDP communicate with me about my protected health information by the following alternative means. Provide full information on the alternative means you want used by the WCDP:

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☐ I request that you communicate with me about my protected health information at the following alternative location. Provide full information on the alternative location:

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SECTION III – SIGNATURES

Please sign the form and complete the appropriate information.

SIGNATURE – Member	Date Signed

If this authorization is signed by a personal representative on behalf of the member, provide a copy of the documentation to support the representation and complete the following:

Name – Personal Representative	Relationship to Member
SIGNATURE – Personal Representative	Date Signed