HIPAA Privacy Form Instructions

HIPAA Privacy Form for:

- CITGO Petroleum Corporation Medical, Dental and Life Insurance Program for Salaried Employees

  and

- CITGO Petroleum Corporation Medical, Dental and Life Insurance Program for Hourly Employees

The above mentioned plans are referred to as the "Plan" on the form.

For definition of "Terms" refer to the Privacy Notice which can be viewed on the CITGO intranet or internet Web sites.

Note: Forms CANNOT be submitted electronically.
Forms must be printed and completed

Completed forms may be submitted via regular mail to:

CITGO Petroleum Corporation
Benefits Department: N5069
HIPAA Services Contact
P.O. Box 4689
Houston, Texas 77210-4689

or

Completed forms may be submitted via fax to 832-486-1842

CITGO Petroleum Corporation
Request for Confidential Communications of Personal Health Plan Information

Form Received By	Date

If you think that disclosure of your health information by the usual means could endanger you in some way, the Plan will accommodate reasonable requests to receive communications of health information from the Plan by alternative means or at alternative locations. If the Payment of benefits is affected by this request, the Plan may also deny this request unless you contact the Communication Contact to discuss alternative Payment means. **Please print, complete and return this form by regular mail or fax.**

1. Employee/Retiree Name	**1a. Employee/Retiree Health Plan ID Number or SSN**
1b. Employee Date of Birth	
2. Name of Person Whose Records You Are Requesting for Confidential Communications	**2a. Relationship to Employee/Retiree** Employee ☐ Spouse ☐ Child ☐ Other ☐
3. Your Name (If not Employee/Retiree)	**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 personal health plan information for the person in Box 2 be provided by alternative means or at alternative locations. I **[check one]** ☐ **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 code ____________________

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**