County/Direct Provider User Cancellation

DHCS Approved (DHCS use only)	
Date	**Approver**

For Canceling User Access to Confidential DHCS Drug Medi-Cal

County/Direct Provider/Vendor: _____

To ensure the confidentiality of county/direct provider Drug Medi-Cal (DMC) data, the Department of Health Care Services (DHCS) requests the County DHCS AOD Administrator, Direct Provider Executive Officer or Vendor Executive Officer to notify DHCS when previously approved users should no longer be allowed access to confidential patient data in the system listed below. Please complete the information below and fax this form to (916) 323-0653. If you have questions about this form, please call (916) 323-2043.

User No Longer Authorized Access as of _____ **(Date)**

First Name: _____ Last Name: _____

Username: _____

Phone Number: _____ Fax Number: _____

Email Address: _____

User No Longer Authorized Access as of _____ **(Date)**

First Name: _____ Last Name: _____

Username: _____

Phone Number: _____ Fax Number: _____

Email Address: _____

User No Longer Authorized Access as of _____ **(Date)**

First Name: _____ Last Name: _____

Username: _____

Phone Number: _____ Fax Number: _____

Email Address: _____

DHCS AOD Administrator/Executive Officer Certification:

As AOD Administrator/Executive Officer for _____ (County/Direct Provider/Vendor), I designate the above individual(s) no longer has/have access requests to specific confidential Drug Medi-Cal patient data.

_____ _____

DHCS AOD Administrator/Executive Officer (signed and printed) Date