Department of Health Care Services
CalOMS
MS 2603
PO Box 997413
Sacramento, CA 95899-7413

CalOMS Tx ITWS County/Direct Provider Approver Form

For Granting Access to the CalOMS Treatment Data System

DHCS Approved	
Date	Approver

County or Direct Provider **Name**: ____________________

County or Direct Provider **Number:** ____________________

To ensure the confidentiality of county/direct provider CalOMS Treatment data, the Department of Health Care Services (DHCS) requires that each County Alcohol and Drug Program Administrator or Direct Provider Executive Officer designate a primary and a secondary contact to be responsible for approving county/direct provider staff requests for ITWS access to confidential patient data in the CalOMS Treatment data system. Please complete and fax this form to DHCS at (916) 322-7117. If you have questions about this form, please call (916) 327-3010 or e-mail CalOMSHelp@DHCS.ca.gov.

Please print all information

Primary Approver (person who approves enrollment form):

First Name: ____________________ Last Name: ____________________

Title: ____________________

Phone Number: (   ) ____________________ Fax Number: (   ) ____________________

Email Address: ____________________

Primary Approver's Signature: ____________________
(Signer acknowledges having read the attached Confidentiality Statement to Users of the Information Technology Web Services (ITWS))

Secondary Approver (person who approves enrollment form):

First Name: ____________________ Last Name: ____________________

Title: ____________________

Phone Number: (   ) ____________________ Fax Number: (   ) ____________________

Email Address: ____________________

Secondary Approver's Signature: ____________________
(Signer acknowledges having read the attached Confidentiality Statement to Users of the Information Technology Web Services (ITWS))

Appointed Vendor(s): (If applicable)

The vendor listed below has the authority to receive, send and process the above-named county/direct provider's confidential CalOMS Treatment information as marked below. The vendor will establish its own primary and secondary approving contacts by completing the Vendor Approver Certification form (DHCS 5100).

Vendor Name: ____________________

Vendor Contact Name: ____________________ Phone Number: (   ) ____________________

County AOD Administrator/Direct Provider Executive Officer Approval:

I hereby approve the above-named individual(s) and vendor, if applicable, to have independent authority to approve access to ITWS confidential CalOMS Treatment patient data. DHCS may rely on approvals, denials, and changes made by the above individual(s)/vendor in its processing of county/direct provider's data in the systems listed above. As changes occur to the above contacts or vendor information (name, phone, e-mail), I will complete a new approver form and forward it to DHCS. Also, I acknowledge reading the Confidentiality Statement to Users of the Information Technology Web Services (ITWS).

____________________ ____________________
Administrator/ Executive Officer (signed and printed) Date