

DHCS Internal Employee Only CalOMS Tx ITWS Approver Form

DHCS Approved	
Date	Approver

For Granting Access to the CalOMS Treatment Data System

DHCS Office/Unit Name: _____

To ensure the confidentiality of CalOMS Treatment data, the Department of Health Care Services (DHCS) requests the appropriate DHCS Office director to designate a primary and a secondary contact to be responsible for approving DHCS office employee requests for 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:

First Name: _____ Last Name: _____

Title: _____

Phone Number: (____) _____ Fax Number: : (____) _____

Email Address: _____

Primary Approver's Signature: _____
(Signer acknowledges having read the Confidentiality Statement for all AOD Patient Data.)

Secondary Approver:

First Name: _____ Last Name: _____

Title: _____

Phone Number: (____) _____ Fax Number: : (____) _____

Email Address: _____

Secondary Approver's Signature: _____
(Signer acknowledges having read the Confidentiality Statement for all AOD Patient Data.)

DHCS DMSS Approval:

I hereby designate the above-named individuals to have independent authority to approve access requests to specific confidential CalOMS Treatment data. The DHCS may rely on approvals, denials, and changes made by these individuals in its processing of access requests to the above selected system(s). As changes occur to the above approving contact's information (name, phone, e-mail or system), I will sign an updated certification and fax it to the appropriate fax numbers listed above. Also, I acknowledge reading the Confidentiality Statement for all AOD Patient Data.

IT Director (signed and printed)

Date