

**CalOMS ITWS County/Direct Provider/Vendor User Cancellation  
For Canceling User Access to the CalOMS Treatment Data System**

<b>DHCS Approved</b>	
<u>Date</u>	<u>Approver</u>

County or Direct Provider or Vendor **Name:** \_\_\_\_\_

County or Direct Provider or Vendor **Number:** \_\_\_\_\_

To ensure the confidentiality of county/direct provider CalOMS Treatment data, the Department of Health Care Services (DHCS) requires that the County Alcohol and Drug Program Administrator or Direct Provider/Vendor Executive Officer notify DHCS when previously-approved users should no longer be allowed 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](mailto:CalOMSHelp@DHCS.ca.gov)

**Please print all information**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Username: \_\_\_\_\_

Phone Number: ( ) \_\_\_\_\_ Fax Number: : ( ) \_\_\_\_\_

Email Address: \_\_\_\_\_

**User no longer authorized access as of \_\_\_\_\_ (date) to the CalOMS Treatment data system.**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Username: \_\_\_\_\_

Phone Number: ( ) \_\_\_\_\_ Fax Number: : ( ) \_\_\_\_\_

Email Address: \_\_\_\_\_

**User no longer authorized access as of \_\_\_\_\_ (date) to the CalOMS Treatment data system.**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Username: \_\_\_\_\_

Phone Number: ( ) \_\_\_\_\_ Fax Number: : ( ) \_\_\_\_\_

Email Address: \_\_\_\_\_

**User no longer authorized access as of \_\_\_\_\_ (date) to the CalOMS Treatment data system.**

**County AOD Administrator/Direct Provider or Vendor Executive Officer:**

I hereby designate that the above-named individual(s) no longer has access rights to confidential patient data in the CalOMS Treatment data system

\_\_\_\_\_  
Administrator/Executive Officer (signed and printed)

\_\_\_\_\_  
Date