State of California
Health and Human Services Agency Department of Health Care Services

CONFIDENTIAL COMMUNICATION REQUEST

File Number: _____

You may request the Department of Health Care Services to contact you at another address or telephone number, other than what is currently in your Medi-Cal records or by a different method (such as only by mail or only by telephone). **Mail this completed form, along with a photocopy of your identification and documentation of your address, to:**

Privacy Officer
Department of Healthcare Services, c/o Office of Legal Services
P.O. Box 997413, MS 0010
Sacramento, CA 95899-7413
(916) 445-4646

Individual Information		
Last Name:	First Name:	Middle Name:
Address:	City/State:	ZIP Code:
Benefits ID Number:	Date of Birth:	
Telephone Number:	E-mail Address:	
I request that the Department of Healthcare Services contact me at a different address and/or different telephone number than what is listed in my Medi-Cal records because contacting me at my current address and/or telephone number is a safety issue for me.		

Alternative Information			
Address:	City/State:	ZIP Code:	Telephone Number:
I may also request that the Department of Healthcare Services to limit the way it contacts me.			
I request that the Department of Healthcare Services contact me: (Please check one) ☐Only by telephone ☐Only by mail			

Identifying Information:
☐Address verification attached Type: _____ (Utility Bill, Phone Bill, Driver's License, Etc.) ☐Copy of identification attached Type: _____ (CA Driver's License, CA DMV Identification Card, Birth Certificate, Benefits Identification Card, Managed Care Card, State Or Federal Employee ID Card) Number: _____

(IF NO IDENTIFICATION IS ATTACHED, YOUR SIGNATURE MUST BE NOTARIZED)

Notarized By _____ On _____ (Date).

Notary Public Number:_____

UNOFFICIAL UNLESS STAMPED BY NOTARY PUBLIC:

I DECLARE UNDER PENALTY OF PERJURY THAT THE INFORMATION ON THIS FORM IS TRUE AND CORRECT.

Member Signature:	Date: