REQUEST TO AMEND PROTECTED HEALTH INFORMATION BY PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE

File Number: _____

You have the right to request amendments to protected health information which Medi-Cal creates or maintains. We will act upon your request to amend within 30 days of our receipt of your request. If your request is denied, we will let you know the reasons for the denial in writing. You have the right to disagree with our denial of your request for amendment. You may tell us why in a written statement of disagreement that will be added to your record. If we continue to disagree with your requested amendment, we may place a note (rebuttal statement) in your record on why we do not agree with your statement of disagreement. We will send you a copy of our rebuttal statement. You also have the right, under the Information Practices Act of 1977, to request a review of the refusal to amend a record by the head of the agency or a designee. **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 Whose Information You Are Amending		
Last Name:	First Name:	Middle Initial:
Address:	City/State:	Zip Code:
Benefits ID Number:	Date of Birth:	Date of Death: (If applicable attach death certificate)

Parent, Guardian, or Personal Representative Information		
Last Name:	First Name:	Middle Initial:
Address:	City/State:	Zip Code:
Benefits ID Number:	Date of Birth:	
Telephone Number:	E-mail Address:	

What Legal Authority Do You Have to Request Health Information	
☐Parent of a minor	☐Administrator of estate
☐Guardian	☐Executor of will
☐Conservator	
☐Other: _____	
Note: You Must Attach Legal Documentation to Verify That You Are the Parent, Conservator, Guardian, Executor of a Decedent's Will, or Have Medical Decision-Making Authority for the Individual.	

Protected Health Information You Want to Amend
Identify the protected health information in your Medi-Cal record you want amended:
What you want the record to state now: (Attach additional paper if necessary)
State the reason you believe the amendment needs to be made:

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: