REQUEST TO RESTRICT USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

File Number: _____

You have the right to request the Department of Health Care Services (DHCS) to restrict the use and disclosure of your Medi-Cal information to carry out treatment, payment or operations. You also have the right to request DHCS not to disclose Medi-Cal information to a family member, relative, or friend involved with your care or payment for your health care. DHCS may not be able to agree with your request. **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 Initial:
Address:	City/State:	Zip Code:
Benefits ID Number:	Date of Birth:	
Telephone Number:	E-mail Address:	

Check All That Apply
☐ **I request that the Department of Healthcare Services restrict use and disclosure of my protected health information in carrying out treatment, payment, or healthcare operations as follows:**
☐ **I request that the Department of Healthcare Services restrict the use and disclosure of my protected health information to the following persons:**

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: