State of California
Health and Human Services Agency

Department of Health Care Services

REQUEST FOR AN ACCOUNTING OF DISCLOSURES OF PROTECTED HEALTH INFORMATION

File Number: ________________

You have the right to request the Department of Health Care Services to account for the disclosures of your Medi-Cal information. You are not entitled to an accounting of disclosures to carry out treatment, payment, or health care operations; when you have authorized the disclosure; or when the disclosure is to your family, relatives, or others involved in your care. You are also not entitled to an accounting of disclosures for National Security intelligence purposes or to law enforcement officials. **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:	

I request that the department of health care services account for the disclosure of my protected health information:

From Date (month/day/year) ________________________

To Date (month/day/year) ________________________

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:

NOTE: ANY ATTEMPT TO FALSELY GAIN ACCESS TO PROTECTED HEALTH INFORMATION IS SUBJECT TO LEGAL PENALTIES.