REQUEST FOR AN ACCOUNTING OF DISCLOSURES OF PROTECTED HEALTH INFORMATION BY PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE

File Number: _____

You have the right to request the Department of Health Care Services to account for the disclosures of 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 the Medi-Cal beneficiary's family, relatives, or others involved in the individuals 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 Health Care 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:	Date of Death: (If applicable attach death certificate)

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) _____

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	☐ Executor of will
☐ Guardian	☐ Administrator of estate
☐ 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.	

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.