State of California-Health and Human Services Agency

Department of Health Services

SANDRA SHEWRY
Director

ARNOLD SCHWARZENEGGER
Governor

April 1, 2005

N.L: 05-0405
Index: Benefits

TO: ALL COUNTY CALIFORNIA CHILDREN'S SERVICES (CCS) ADMINISTRATORS AND MEDICAL CONSULTANTS, CHILD HEALTH AND DISABILITY PREVENTION (CHOP) PROGRAM DIRECTORS AND DEPUTY DIRECTORS, AND STATE CHILDREN'S MEDICAL SERVICES (CMS) STAFF

SUBJECT: AUTHORIZATION OF DIAGNOSTIC SERVICES FOR INFANTS REFERRED BY THE CALIFORNIA NEWBORN SCREENING PROGRAM

I. Background

The California Newborn Screening Program currently screens more than 500,000 newborns annually for phenylketonuria (PKU), galactosemia, primary congenital hypothyroidism, and hemoglobinopathies including sickle cell disease. All the conditions for which the California Newborn Screening Program screens are CCS-eligible. Over 99 percent of the babies born in California are tested. Through this mandatory screening program, about 500 newborns with these disorders are identified and treated every year. When these disorders are diagnosed late or left undiagnosed, serious disabilities and even death can result.

Annually, we estimate that approximately 75 referrals are made to metabolic centers (PKU & galactosemia), 175 to sickle cell disease/hematology centers, and 700 to endocrine centers for diagnostic evaluations throughout the state.

II. Policy

A. CCS shall issue an authorization to a CCS-approved Special Care Center (SCC) to perform a diagnostic evaluation on **ALL** infants referred by the California Newborn Screening Program. The California Newborn Screening Program staff will identify the SCC to which the infant will be referred. The SCC may be metabolic, endocrine, sickle cell or hematology depending on the screening result.

B. These authorizations shall be issued within five working days of receipt of the referral.

C. Issuance of this authorization for diagnostic services shall be done upon receipt of a CCS Request for Service form and a signed CCS application. Authorizations shall be issued without a signed CCS application for infants who have full scope no share of cost Medi-Cal or who are Healthy Families subscribers.

D. The CCS $20 assessment fee is to be waived for these services.

III, Policy Implementation

A. Authorizations shall include the following information:

Claims for services provided to children with other third-party coverage must be submitted to the insurance carrier or health maintenance organization prior to billing either the CCS or Medi-Cal program for the services. A denial of payment from the third-party payer must accompany the claim.

B. For infants whose diagnostic evaluation confirms the presence of a metabolic, endocrine or hematologic disorder, the CCS program shall initiate the steps to determine eligibility for ongoing treatment services.

1. Authorizations for treatment services shall be issued to CCS approved Metabolic, Endocrine, Sickle Cell or Hematology SCCs for infants who have full scope, no share of cost Medi-Cal.

2. Families of other infants must complete program eligibility requirements prior to the issuance of treatment authorizations.

On or before August 1, 2005, the California Newborn Screening Program will be expanded to include congenital adrenal hyperplasia and a large number of inborn errors of metabolism. A subsequent numbered letter will address these conditions and provide direction for authorizations.

If you have any questions regarding the above policy, please contact your Regional Office Medical Consultant.

Original Signed by Marian Daisey, M.D., M.P.H.

Marian Daisey, M.D., M.P.H., Acting Chief
Children's Medical Services Branch

Enclosure

Overview of the Genetic Disease Branch Newborn Screening Program

The Newborn Screening Program begins with the education of prenatal care providers and hospital staff. The prenatal care providers distribute a copy of the informational booklet, *Important Information for Parents about the Newborn Screening Test,* to women during their pregnancy. This booklet describes mandatory newborn screening. Because some women do not receive prenatal care, the booklet is also provided to women upon admission to a licensed perinatal health facility for delivery. The actual sample of newborn blood is obtained after 12 hours of age and before the sixth day of life by a heel-stick. The blood sample is collected on special filter paper, and mailed to the pre-assigned regional state contract laboratory for testing. These laboratories process the specimen and enter demographic data and test results on terminals linked to a Genetic Disease Branch central computer in Richmond, California. A computer-generated written report of all tests, referred to as a "result mailer" is mailed to the hospital that collected the specimen. Another copy is mailed to the baby's physician as listed by the hospital of birth on the Newborn Screening Specimen Collection Form (also referred to as the "test request form" or **TRF).**

Because of the urgency for treatment, all initial positive test results for PKU, galactosemia and primary congenital hypothyroidism are immediately reported by telephone by the NAPS lab to assigned newborn screening coordinators. These coordinators arc located at one of the seven state-funded Area Service Centers (ASC) and are linked to the state central computer in Richmond, CA. The State Genetic Disease Laboratory (GDL) reviews and releases hemoglobin results. Potentially clinically significant hemoglobinopathies and other initial positive results are reported on a daily "Interesting Case Report" to the Centers. The coordinators from the Centers immediately telephone the newborn's physician to provide interpretation of the test and explain necessary follow-up. Medical consultants and specialists are also available to provide additional information and consultation when necessary.
If the initial tests are not within normal limits, a second blood sample called a "recall specimen" is collected (see attached flow chart). The recall specimens for phenylketonuria are sent to GDL for testing. Recall specimens for galactosemia are sent to a state-contract galactosemia confirmation laboratory at Children's Hospital of Los Angeles, while those for hemoglobin disorders are sent to the state hemoglobin reference laboratory at Children's Hospital and Research Center at Oakland. In the past, filter paper recall specimens for TSH were also sent to **GDL** for testing. As of February 2005, the state laboratory will no longer conduct recall testing on filter paper blood specimens for primary congenital hypothyroidism, and providers will be required to have a venous blood specimen collected/tested at a private California licensed laboratory (including hospital laboratories). Test results will then be reported to the NBS Program via the assigned (ASC).

The NBS coordinators notify the newborn's physician of the recall test results. Because primary care physicians are often unfamiliar with these rare disorders, the coordinator will assist the provider in referring a family to a California Children's Services (CCS)-approved metabolic, endocrine or sickle cell disease

center/hematology center for specialized diagnosis and treatment. The comprehensive team approach to care offered at the Centers is particularly important in treatment of these disorders.

The coordinators also directly contact the parents of the newborn by telephone to discuss the need for confirmatory testing or a diagnostic evaluation. After contacting the parents, the coordinator faxes a referral form to the appropriate CCS office requesting an authorization for diagnostic evaluation al a CCS approved center, or in certain circumstances, a CCS paneled specialist (e.g. pediatric endocrine, pediatric hematologist) not affiliated with a center. The coordinator schedules the appointment at the center and will send the parents a letter to the mother containing information about CCS and CCS application form, with instructions for submission and the date of the appointment. It is anticipated that this process will expedite the referral and the care of the newborn. Once care is authorized, the center will make the arrangements for any further confirmatory/diagnostic testing and develop if needed the treatment plan.

IDENTIFYING INFORMATION

☐ COPY OF IDENTIFICATION ATTACHED

TYPE: ______________________ (CA DRIVER'S LICENSE, CA OMV IDENTIFICATION CARD, STATE OR FEDERAL EMPLOYEE ID CARD)

NUMBER: ______________________

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

CLIENT SIGNATURE: DATE:

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

NOTARIZED BY: ______________________ ON (DATE)

NOTARY PUBLIC NUMBER: ______________________

UNOFFICIAL UNLESS STAMPED BY NOTARY PUBLIC:

☐ ADDRESS VERIFICATION ATTACHED

FORM OF ADDRESS VERIFICATION (UTILITY BILL, PHONE BILL, DRIVER'S LICENSE, ETC.)

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

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

TEMPLATE

File Number:__________________

You have the right to request amendments to protected health information which ____ County California Children's Services (CCS) Medical Therapy Program (MTP) 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, with a photocopy of your identification and documentation of your address, to:

Attention: HIPAA Representative
_________County California Children's Services
Medical Therapy Program
(Insert County Address)
(Insert County Telephone Number)

CLIENT WHOSE INFORMATION YOU ARE AMENDING		
LAST NAME:	FIRST NAME:	MIDDLE INITIAL:
ADDRESS:	CITY/STATE:	ZIP CODE:
CLIENT INDEX NUMBER (CID):	DATE OF BIRTH:	DATE OF DEATH: (IF APPLICABLE)
DEATH CERTIFICATE MUST BE ATTACHED		
PARENT, GUARDIAN, OR LEGAL REPRESENTATIVE INFORMATION		
LAST NAME:	FIRST NAME:	MIDDLE INITIAL:
ADDRESS:	CITY/STATE:	ZIP CODE:

DAYTIME TELEPHONE ,-.JUMBER: ( )	EVENING TELEPHONE NUMBER: ( )	EMAIL ADDRESS:	BEST HOURS TO REACH YOU:

WHAT LEGAL AUTHORITY DO YOU HAVE TO AMEND THE HEALTH INFORMATION OF THE CLIENT ABOVE?

☐ PARENT
☐ CONSERVATOR
☐ GUARDIAN
☐ EXECUTOR OF WILL
☐ MEDICAL POWER OF ATTORNEY
☐ OTHER

PLEASE ATTACH LEGAL DOCUMENTATION VERIFYING THAT YOU ARE THE PARENT, CONSERVATOR, GUARDIAN, EXECUTOR OF A DECEDENT'S WILL, OR HAVE MEDICAL DECISION-MAKING AUTHORITY FOR THE CLIENT.

PROTECTED HEALTH INFORMATION YOU WANT TO AMEND

IDENTIFY THE PROTECTED HEALTH INFORMATION IN THE CLIENT'S CCS MTP 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:

IDENTIFY THE PERSON(S) TO WHOM YOU WANT THE CCS MTP TO SEND THE PHI AMENDMENT(S). PROVIDE FULL NAME, ADDRESS, AND ZIP CODE. UPON APPROVAL, AMENDMENT(S) WILL BE SENT TO PERSON(S) IDENTIFIED, AND TO PROVIDERS, HEALTH PLANS, AND OTHER BUSINESS ASSOCIATES OF CCS MTP PREVIOUSLY SENT THE CLIENTS PHI.

IDENTIFYING INFORMATION

☐ COPY OF IDENTIFICATION ATTACHED

TYPE:__________________________(CA DRIVER'S LICENSE, CA DMV IDENTIFICATION CARD, STATE OR FEDERAL EMPLOYEE ID CARD)

NUMBER:_________________________

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

LEGAL REPRESENTATIVE SIGNATURE: DATE:

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

NOTARIZED BY: ________________________________ON _________________(DATE}

NOTARY PUBLIC NUMBER: __________________________

UNOFFICIAL UNLESS STAMPED BY NOTARY PUBLIC:

☐ ADDRESS VERIFICATION ATTACHED

FORM OF ADDRESS VERIFICATION ___________________________(UTILITY BILL, PHONE BILL, DRIVER'S LICENSE, ETC.)

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

REQUEST TO RESTRICT USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

TEMPLATE

File Number:__________________

You have the right to request the ____ County California Children's Services (CCS) Medical Therapy Program (MTP) to restrict the use and disclosure of your CCS MTP protected health information to carry out treatment, payment or operations. You also have the right to request __ County CCS MTP not to disclose CCS MTP protected health information to a family member, relative, or friend involved with your care or payment for your health care. ____ County CCS MTP may not be able to agree with your request. This form must be accompanied by a photocopy of a form of identification and documentation of your address. Mail this completed form to:

Attention: HIPAA Representative
--- California Children's Services
Medical Therapy Program
(Insert County Address)
(Insert County Telephone Number)

CLIENT INFORMATION

LAST NAME:		FIRST NAME:		MIDDLE INITIAL:
ADDRESS:		CITY/STATE:		ZIP CODE:
CLIENT INDEX NUMBER (CIN):		DATE BIRTH:		
DAYTIME TELEPHONE NUMBER: ( )	EVENING TELEPHONE NUMBER: ( )	EMAIL ADDRESS:	BEST HOURS TO REACH YOU:	

CHECK ALL THAT APPLY

☐ **I REQUEST THAT THE COUNTY CCS MTP RESTRICT USE AND DISCLOSURE OF MY MTP PROTECTED HEALTH INFORMATION IN CARRYING OUT TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS AS FOLLOWS:**

☐ I **REQUEST THAT THE COUNTY CCS MTP RESTRICT THE USE AND DISCLOSURE OF THE MTP PROTECTED HEALTH INFORMATION TO THE FOLLOWING PERSONS:**

[PLEASE PROVIDE THE NAMES AND RELATIONSHIP OF ANY FAMILY MEMBERS, RELATIVES, OR OTHER IDENTIFIED PERSONS TO WHOM YOU DO NOT WANT MTP TO DISCLOSE INFORMATJON.]

IDENTIFYING INFORMATION

☐ COPY OF IDENTIFICATION ATTACHED

TYPE: ______________________ (CA DRIVER'S LICENSE, CA OMV IDENTIFICATION CARD, STATE OR FEDERAL EMPLOYEE ID CARD)

NUMBER: ______________________

I **UNDERSTAND THE COUNTY CCS MTP MAY NOT AGREE TO REQUESTED RESTRICTION(S), BUT WILL NOTIFY ME OF ITS RESPONSE TO MY REQUEST.**

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

CLIENT SIGNATURE: DATE:

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

NOTARIZED BY: ______________________ ON (DATE)

NOTARY PUBLIC NUMBER: ______________________

UNOFFICIAL UNLESS STAMPED BY NOTARY PUBLIC:

☐ ADDRESS VERIFICATION ATTACHED

FORM OF ADDRESS VERIFICATION (UTILITY BILL, PHONE BILL, DRIVER'S LICENSE, ETC.)

REQUEST TO RESTRICT USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION BY PARENT, GUARDIAN OR LEGAL REPRESENTATIVE

TEMPLATE

File Number:__________________

You have the right to request the ____ County California Children's Services (CCS) Medical Therapy Program (MTP) to restrict the use and disclosure of the CCS MTP protected health information to carry out treatment, payment or operations. You also have the right to request ___ County CCS MTP not to disclose CCS MTP protected health information to a family member, relative, or friend involved with the care or payment of the individual's health care. ____ County CCS MTP may not be able to agree with your request. This form must be accompanied by a photocopy of a form of identification and documentation of your address. Mail this completed form to:

Attention: HIPAA Representative
___ County California Children's Services
Medical Therapy Program
(Insert County Address)
(Insert County Telephone Number)

CLIENT FOR WHOM YOU ARE REQUESTING TO RESTRICT THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION		
LAST NAME:	FIRST NAME:	MIDDLE INITIAL:
ADDRESS:	CITY/STATE:	ZIP CODE:
CLIENT INDEX NUMBER (CIN):	DATE OF BIRTH:	DATE OF DEATH: (If Applicable)
DEATH CERTIFICATE MUST BE ATTACHED		

PARENT, GUARDIAN, OR LEGAL REPRESENTATIVE INFORMATION			
LAST NAME:	FIRST NAME:		MIDDLE INITIAL:
ADDRESS:	CITY/STATE:		ZIP CODE:
DAYTIME TELEPHONE NUMBER: ( )	EVENING TELEPHONE NUMBER: ( )	EMAIL ADDR	BEST HOURS TO REACH YOU:

WHAT LEGAL AUTHORITY DO YOU HAVE TO RESTRICT THE HEALTH INFORMATION OF THE CLIENT ABOVE?

0 PARENT
0 CONSERVATOR
0 GUARDIAN
0 EXECUTOR OF WILL
0 MEDICAL POWER OF ATTORNEY
0 OTHER

PLEASE ATTACH LEGAL DOCUMENTATION VERIFYING THAT YOU ARE THE PARENT, CONSERVATOR, GUARDIAN, EXECUTOR OF A DECEDENT'S WILL, OR HAVE MEDICAL DECISION-MAKING AUTHORITY FOR THE CLIENT.

CHECK ALL THAT APPLY

☐ **I REQUEST THAT THE COUNTY CCS MTP RESTRICT THE USE AND DISCLOSURE OF THE CLIENT'S PROTECTED HEALTH INFORMATION IN CARRYING OUT TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS AS FOLLOWS:**

0 **I REQUEST THAT COUNTY CCS MTP RESTRICT THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION TO THE FOLLOWING PERSONS:**

[PLEASE PROVIDE THE NAMES AND RELATIONSHIP OF ANY FAMILY MEMBERS, RELATJVES, OR OTHER IDENTIFIED PERSONS TO WHOM YOU DO NOT WANT OHS TO DISCLOSE INFORMATION.]

IDENTIFYING INFORMATION

0 COPY OF IDENTIFICATION ATTACHED

TYPE: ______________________ (CA DRIVER'S LICENSE, CA OMV IDENTIFICATION CARD, STATE OR FEDERAL EMPLOYEE ID CARD)

NUMBER: ______________________

I UNDERSTAND THE DEPARTMENT OF HEALTH SERVICES MAY NOT AGREE TO REQUESTED RESTRICTION(S), BUT WILL NOTIFY ME OF ITS RESPONSE TO MY REQUEST.

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

LEGAL REPRESENTATIVE SIGNATURE: DATE:

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

NOTARIZED BY: _ ON (DATE)

NOTARY PUBLIC NUMBER:

UNOFFICIAL UNLESS STAMPED BY NOTARY PUBLIC:

0 ADDRESS VERIFICATION ATTACHED

FORM OF ADDRESS VERIFICATION (UTILITY BILL, PHONE BILL, DRIVER'S LICENSE, ETC.)

REQUEST FOR AN ACCOUNTING OF DISCLOSURES OF PROTECTED HEALTH INFORMATION

TEMPLATE

File Number:___________________

You have the right to request the ____ County California Children's Services (CCS) Medical Therapy Program (MTP) to account for the disclosures of your protected health 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 or intelligence purposes and to law enforcement officials. A photocopy of your identification and documentation of your address must accompany this form. Mail this completed form to:

Attention: HIPAA Representative
___ County California Children's Services
Medical Therapy Program
(Insert County Address)
(Insert County Telephone Number)

<table>
<tr><th colspan="4">CLIENT INFORMATION</th></tr>
<tr><td colspan="2">LAST NAME:</td><td>FIRST NAME:</td><td>MIDDLE INITIAL:</td></tr>
<tr><td colspan="2">ADDRESS:</td><td>CITY/STATE:</td><td>ZIP CODE:</td></tr>
<tr><td colspan="2">CLIENT INDEX NUMBER (CID):</td><td colspan="2">DATE OF BIRTH:</td></tr>
<tr><td>DAYTIME TELEPHONE NUMBER:
(   )</td><td>EVENING TELEPHONE NUMBER:
(   )</td><td>EMAIL ADDRESS:</td><td>BEST HOURS TO REACH YOU:</td></tr>
<tr><th colspan="4">IDENTIFYING INFORMATION</th></tr>
<tr><td colspan="4">☐ COPY OF IDENTIFICATION ATTACHED

TYPE:________________ (CA DRIVER'S LICENSE, CA OMV IDENTIFICATION CARD, STATE OR FEDERAL EMPLOYEE ID CARD)

NUMBER:______________________________</td></tr>
</table>

I REQUEST THAT THE COUNTY CCS MTP ACCOUNT FOR THE DISCLOSURE OF MY PROTECTED HEALTH INFORMATION.

FROM: (MONTH/YEAR) TO: ___________ (MONTH/YEAR)

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

CLIENT SIGNATURE: ______________________________ DATE: ________________________

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

NOTARIZED BY: ______________________________ ON (DATE)

NOTARY PUBLIC NUMBER: ______________________

UNOFFICIAL UNLESS STAMPED BY NOTARY PUBLIC:

0 ADDRESS VERIFICATION ATTACHED

FORM OF ADDRESS VERIFICATION ______________________ (UTILITY BILL, PHONE BILL, DRIVER'S LICENSE, ETC.)

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

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

TEMPLATE

File Number:____________________

You have the right to request the ____ County California Children's Services (CCS) Medical Therapy Program (MTP) to account for the disclosures of personal CCS MTP protected health 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 CCS MTP client's family, relatives, or others involved in the client's care. You are also not entitled to an accounting of disclosures for National Security or intelligence purposes and to law enforcement officials. A photocopy of your identification and documentation of your address must accompany this form. Mail this completed form to:

Attention: HIPAA Representative
___ County California Children's Services
Medical Therapy Program
(Insert County Address)
(Insert County Telephone Number)

CLIENT FOR WHOM YOU ARE REQUESTING AN ACCOUNTING OF DISCLOSURES			
LAST NAME:	FIRST NAME:		MIDDLE INITIAL:
ADDRESS:	CITY/STATE:		ZIP CODE:
CLIENT INDEX NUMBER (CID):	DATE OF BIRTH:	DATE OF DEATH: (IF APPLICABLE)	
DEATH CERTIFICATE MUST BE ATTACHED			
PARENT, GUARDIAN, OR LEGAL REPRESENTATIVE INFORMATION			
LAST NAME:	FIRST NAME:		MIDDLE INITIAL:
ADDRESS:	CITY/STATE:		ZIP CODE:

DAYTIME TELEPHONE NUMBER: ( )	EVENING TELEPHONE NUMBER: ( )	EMAIL ADDRESS:	BEST HOURS TO REACH YOU:

WHAT LEGAL AUTHORITY DO YOU HAVE TO REQUEST AN ACCOUNTING OF DISCLOSURES FOR THE CLIENT ABOVE?

0 PARENT
0 CONSERVATOR
0 GUARDIAN
0 EXECUTOR OF WILL
0 MEDICAL POWER OF ATTORNEY
0 OTHER

PLEASE ATTACH LEGAL DOCUMENTATION VERIFYING THAT YOU ARE THE PARENT, CONSERVATOR, GUARDIAN, EXECUTOR OF A DECEDENT'S WILL, OR HAVE MEDICAL DECISION-MAKING AUTHORITY FOR THE CLIENT.

IDENTIFYING INFORMATION

0 COPY OF IDENTIFICATION ATTACHED

TYPE: ____________________ (CA DRIVER'S LICENSE, CA DMV IDENTIFICATION CARD, STATE OR FEDERAL EMPLOYEE ID CARD)

NUMBER: ______________________________

I REQUEST THAT THE ____________ COUNTY CCS MTP ACCOUNT FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION.

FROM: ____________________ (MONTH/YEAR) TO: ____________________ (MONTH/YEAR)

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

LEGAL REPRESENTATIVE
SIGNATURE: ______________________ DATE: ______________

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

NOTARIZED BY: ________________________________ ON __________________(DATE)

NOTARY PUBLIC NUMBER: ____________________________

UNOFFICIAL UNLESS STAMPED BY NOTARY PUBLIC:

☐ ADDRESS VERIFICATION ATTACHED

FORM OF ADDRESS VERIFICATION ____________________________ (UTILITY BILL, PHONE BILL, DRIVER'S LICENSE, ETC.)

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