# CONFIDENTIAL

# REQUEST TO ACCESS PERSONAL INFORMATION BY PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE

As a parent, guardian, or personal representative you have the right to inspect the personal records of the individual you are authorized to represent, which the California Department of Public Health collects, creates or maintains. You also have the right to request copies of the records. You will be charged ten (10) cents per page for the costs of copying. You will receive a response to your request within 15 days after we receive your request and payment. If you want copies of the records mailed, you need to send us a photocopy of your California Driver's License, Department of Motor Vehicles Identification Card, other valid identification, and documentation verifying your authority to represent the stated individual. You will also need to send documentation verifying your address. Note: Any attempt to falsely gain access to personal information is subject to legal penalties. Checks should be made payable to the California Department of Public Health. **Mail or fax this completed form to**:

Privacy Officer
California Department of Public Health
P.O. Box 997377, MS 0506
Sacramento, CA 95899-7377
(916) 440-7714 (fax)

## INDIVIDUAL WHOSE INFORMATION YOU ARE REQUESTING

| LAST NAME: | FIRST NAME: | MIDDLE INITIAL: |
|---|---|---|
| ADDRESS: | CITY/STATE: | ZIP CODE: |
| BENEFICIARY ID NUMBER: | DATE OF BIRTH: | DATE OF DEATH (If applicable): **Death Certificate Must Be Attached** |

## PARENT, GUARDIAN, OR PERSONAL REPRESENTATIVE INFORMATION

| LAST NAME: | FIRST NAME: | MIDDLE INITIAL: | |
|---|---|---|---|
| ADDRESS: | CITY/STATE: | ZIP CODE: | |
| DAYTIME TELEPHONE NUMBER (Required): ( ) ________ | EVENING TELEPHONE NUMBER ( ) ________ | EMAIL ADDRESS: | BEST HOURS TO REACH YOU: |

## WHAT LEGAL AUTHORITY DO YOU HAVE TO REQUEST PERSONAL INFORMATION ABOUT THE INDIVIDUAL LISTED ABOVE?

- ☐ PARENT
- ☐ GUARDIAN
- ☐ MEDICAL POWER OF ATTORNEY
- ☐ CONSERVATOR
- ☐ EXECUTOR OF WILL
- ☐ 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.

## DIRECTIONS

WHICH CDPH PROGRAM(S) HAS/HAVE THE PERSONAL INFORMATION OF THE INDIVIDUAL ABOVE THAT YOU WANT TO ACCESS?

- ☐ AIDS Drug Assistance Program (ADAP)
- ☐ AIDS Medi-Cal Waiver Program (MCWP)
- ☐ Children's Treatment Program (CTP)
- ☐ Emergency Medical Services Appropriation (EMSA)
- ☐ Every Woman Counts (CDS:EWC)
- ☐ Family Planning Access, Care, & Treatment (FPACT)
- ☐ Newborn Screening Program
- ☐ Refugee Health Services
- ☐ Prenatal Screening Program
- ☐ Prostate Cancer Treatment Program (IMPACT)
- ☐ Therapeutic Monitoring Program (TMP)
- ☐ Viral and Rickettsial Disease Laboratory (VRDL)
- ☐ OTHER (Please list CDPH program(s) which may have the personal information)
  ____________________
  ____________________
- ☐ UNKNOWN (If this box is checked, we will call you to assist in determining which CDPH program(s) may have the personal information you are requesting.)

## I AM REQUESTING COPIES OF RECORDS FOR THE FOLLOWNG DATES

YOU MUST SPECIFY DATES IN ORDER TO GET RECORDS

| FROM DATE (month/day/year) | TO DATE (month/day/year) |
|---|---|
| | |

PLEASE NOTE**:** FULFILLING A REQUEST FOR RECORDS DATING BACK 6 YEARS AGO OR LESS IS A 30-DAY PROCESS. REQUESTS FOR RECORDS DATING BACK PRIOR TO 6 YEARS AGO HAVE A 60-DAY TIME FRAME FOR ADDITIONAL PROCESSING.

☐ PLEASE MAIL ME A COPY OF THE REQUESTED INFORMATION.

☐ I WISH TO REVIEW THE REQUESTED INFORMATION IN PERSON.

IF YOU REQUEST TO REVIEW RECORDS IN PERSON, YOU WILL BE CONTACTED TO SCHEDULE AN APPOINTMENT. LOCATION AVAILABLE FOR IN PERSON REVIEW: **SACRAMENTO ONLY**

☐ I REQUEST THAT A PERSON OF MY CHOOSING BE ALLOWED TO INSPECT THE RECORDS.

NOTE: Any person or attorney may be named below. Records will not be sent to photocopy services.

NAME: ______________________________

RELATIONSHIP TO YOU: ______________________

TELEPHONE NUMBER: (____) ____________________

ADDRESS: ______________________________

## IDENTIFYING INFORMATION IS REQUIRED

☐ COPY OF 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.**

REQUESTING REPRESENTATIVE SIGNATURE: ______________________________ DATE: __________

## DEPARTMENT EMPLOYEE PROCESSING/MAINTAINING THIS ACCESS REQUEST

THIS SECTION TO BE COMPLETED BY DEPARTMENT STAFF

______________________________________________

(Name and Title)

| ______________________ | ______________________ | ______________________ |
|---|---|---|
| (Organization within Department) | (Telephone Number) | (Mail Stop Number) |

## PRIVACY STATEMENT (CA CIVIL CODE SECTION 1798 .17)

THE INFORMATION COLLECTED ON THIS FORM IS USED TO PROCESS YOUR REQUEST FOR ACCESS TO PERSONAL INFORMATION ABOUT AN INDIVIDUAL YOU LEGALLY REPRESENT THAT IS MAINTAINED BY THE CALIFORNIA DEPARTMENT OF PUBLIC HEALTH (DEPARTMENT). THE INFORMATION WE COLLECT FROM YOU ON THIS FORM WILL BE KEPT CONFIDENTIAL AND ON FILE AT THE DEPARTMENT, AS REQUIRED BY LAW. ALL INFORMATION REQUESTED ON THE FORM IS MANDATORY PURSUANT TO CALIFORNIA CIVIL CODE SECTION 1798.32. NOT SUPPLYING THE INFORMATION REQUESTED WILL RESULT IN THE DENIAL OF YOUR REQUEST. ANY INFORMATION PROVIDED MAY BE DISCLOSED TO THE CALIFORNIA STATE AUDITOR, THE CALIFORNIA OFFICE OF HEALTH INFORMATION INTEGRITY, THE CALIFORNIA OFFICE OF INFORMATION SECURITY AND PRIVACY PROTECTION, THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES OR TO OTHER STATE AND FEDERAL AGENCIES AS REQUIRED BY LAW.

YOU HAVE THE RIGHT TO REVIEW THE RECORDS WE KEEP ABOUT YOU DURING NORMAL BUSINESS HOURS. THE CALIFORNIA DEPARTMENT OF PUBLIC HEALTH PRIVACY OFFICER WILL, UPON REQUEST, INFORM YOU REGARDING THE LOCATION OF YOUR RECORDS AND THE CATEGORIES OF ANY PERSONS WHO USE THE INFORMATION IN THOSE RECORDS. FOR MORE INFORMATION, CONTACT THE CALIFORNIA DEPARTMENT OF PUBLIC HEALTH, PRIVACY OFFICE, USING THE FOLLOWING CONTACT INFORMATION: CALIFORNIA DEPARTMENT OF PUBLIC HEALTH, OFFICE OF LEGAL SERVICES, PRIVACY OFFICE, MS 0506, P.O. BOX 997377, SACRAMENTO, CALIFORNIA 95899-7377 OR BY PHONE 1-877-421-9634.