CONFIDENTIAL

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

You have the right to request the California Department of Public Health to provide an accounting to you of the disclosures of personal information. There is no charge for the accounting. You will receive a response to your request within 15 days after we receive your request. To obtain the accounting, you need to send us a photocopy of your California Driver 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 (see below). **Note**: Any attempt to falsely gain access to personal information is subject to legal penalties. **Mail, fax or email this completed form to**:

Privacy Officer
California Department of Public Health
1415 L Street, Suite 500
Sacramento, CA 95814
(916) 319-9821 (fax)
privacy@cdph.ca.gov (email)

INDIVIDUAL FOR WHOM YOU ARE REQUESTING AN ACCOUNTING OF DISCLOSURES

LAST NAME:	FIRST NAME:	MIDDLE INITIAL:
ADDRESS:	CITY/STATE:	ZIP CODE:
BENEFICIARY ID NUMBER:	DATE OF BIRTH:	DATE OF DEATH: (If applicable) Death Certification 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 AN ACCOUNTING OF DISCLOSURES

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

☐ COPY OF LEGAL DOCUMENTATION ATTACHE
TYPE (COURT ORDER/APPOINTMENT OF CONSERVATOR, GUARDIAN, ETC., MEDICAL POWER OF ATTORNEY, ATTORNEY LETTER OF REPRESENTATION, APPOINTMENT OF GUARDIAN AD LITEM, ETC.): _____

DIRECTIONS

WHICH CDPH PROGRAM(S) ARE YOU REQUESTING AN ACCOUNTING OF DISCLOSURE FROM?

☐ AIDS Drug Assistance Program (ADAP)
☐ AIDS Medi-Cal Waiver Program (MCWP)
☐ Newborn Screening Program
☐ Prenatal Screening Program
☐ 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 AN ACCOUNTING OF DISCLOSURES OF RECORDS FOR THE FOLLOWING DATES

YOU MUST SPECIFY DATES IN ORDER TO RECEIVE AN ACCOUNTING

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

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

DELIVERY OF ACCOUNTING

☐ PLEASE MAIL ME A COPY OF THE ACCOUNTING

☐ PLEASE FAX ME A COPY OF THE ACCOUNTING

FAX NUMBER _____

☐ I REQUEST THAT A PERSON OF MY CHOOSING BE ALLOWED TO RECEIVE A COPY OF THE ACCOUNTING

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

NAME: _____

RELATIONSHIP TO YOU: _____

TELEPHONE NUMBER: _____

ADDRESS: _____

REQUIRED IDENTIFYING INFORMATION

To process your request, you must provide verification of address and identification.

☐ ADDRESS VERIFICATION ATTACHED
TYPE (UTILITY BILL, PHONE BILL, DRIVER'S LICENSE, ETC.): _____

☐ COPY OF IDENTIFICATION ATTACHED
TYPE (DRIVER'S LICENSE, 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 REQUEST FOR AN ACCOUNTING

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 AN ACCOUNTING OF DISCLOSURES OF 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, 1415 L STREET, SUITE 500, SACRAMENTO, CALIFORNIA 95814 OR BY PHONE 1-877-421-9634.