CONFIDENTIAL

REQUEST TO RESTRICT USE AND DISCLOSURE OF PERSONAL INFORMATION BY PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE

You have the right to request the California Department of Public Health (CDPH) to restrict the use and disclosure of personal information to carry out treatment, payment or operations. You also have the right to request CDPH not to disclose personal information to a family member, relative, or friend involved with care or payment for the individual's health care. **NOTE: CDPH may refuse to agree to your requested restriction(s) but will notify you of its refusal in its response to your request**. This form must be accompanied by a photocopy of your California driver's license, Department of Motor Vehicles Identification Card, or other valid identification. You will also need to send another type of documentation verifying your address (see below). **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 WHOSE INFORMATION YOU ARE REQUESTING TO RESTRICT THE USE AND DISCLOSURE OF PERSONAL INFORMATION

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 RESTRICT THE USE AND DISCLOSURE OF 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.

☐ COPY OF LEGAL DOCUMENTATION ATTACHED
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) HAS/HAVE THE PERSONAL INFORMATION OF THE INDIVIDUAL ABOVE THAT YOU WANT TO RESTRICT USE AND DISCLOSURE OF?

☐ 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 we restrict the use and disclosure.)

CHECK ALL THAT APPLY

☐ **I REQUEST THAT THE CALIFORNIA DEPARTMENT OF PUBLIC HEALTH RESTRICT USE AND DISCLOSURE OF THE INDIVIDUAL'S PERSONAL INFORMATION IN CARRYING OUT TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS AS FOLLOWS:**

☐ **I REQUEST THAT THE CALIFORNIA DEPARTMENT OF PUBLIC HEALTH RESTRICT THE DISCLOSURE OF PERSONAL INFORMATION FROM THE FOLLOWING PERSONS:**

PLEASE PROVIDE THE NAMES OF ANY FAMILY MEMBERS, RELATIVES… TO WHOM YOU DO NOT WANT CDPH TO DISCLOSE INFORMATION IN THE SPACE ABOVE.

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.

REPRESENTATIVE SIGNATURE: _____ DATE: _____

DEPARTMENT EMPLOYEE PROCESSING/MAINTAINING THIS REQUEST FOR RESTRICTION ON USE AND DISCLOSURE OF PERSONAL INFORMATION

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 TO RESTRICT USE AND DISCLOSURE 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 TITLE 45, CODE OF FEDERAL REGULATIONS, SECTION 164.522. 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.