

CONFIDENTIAL

**REQUEST FOR CONFIDENTIAL COMMUNICATION OF
PERSONAL INFORMATION BY PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE**

You may request the California Department of Public Health to contact you at another address or telephone number, other than what is in the individual's personal records or by a different method (such as only by mail or only by telephone). To obtain the confidential communication, 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 (see below). **Note:** Any attempt to falsely gain access to personal information is subject to legal penalties. **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 FOR WHOM YOU ARE REQUESTING A CONFIDENTIAL COMMUNICATION			
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 A CONFIDENTIAL COMMUNICATION ABOUT THE INDIVIDUAL LISTED ABOVE?			
<input type="checkbox"/> PARENT <input type="checkbox"/> GUARDIAN <input type="checkbox"/> MEDICAL POWER OF ATTORNEY		<input type="checkbox"/> CONSERVATOR <input type="checkbox"/> EXECUTOR OF WILL <input type="checkbox"/> 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) ARE YOU REQUESTING A CONFIDENTIAL COMMUNICATION?			
<input type="checkbox"/> AIDS Drug Assistance Program (ADAP) <input type="checkbox"/> AIDS Medi-Cal Waiver Program (MCWP) <input type="checkbox"/> Children's Treatment Program (CTP) <input type="checkbox"/> Emergency Medical Services Appropriation (EMSA) <input type="checkbox"/> Every Woman Counts (CDS:EWC) <input type="checkbox"/> Family Planning Access, Care, & Treatment (FPACT) <input type="checkbox"/> Newborn Screening Program <input type="checkbox"/> Refugee Health Services		<input type="checkbox"/> Prenatal Screening Program <input type="checkbox"/> Prostate Cancer Treatment Program (IMPACT) <input type="checkbox"/> Therapeutic Monitoring Program (TMP) <input type="checkbox"/> Viral and Rickettsial Disease Laboratory (VRDL) <input type="checkbox"/> OTHER (Please list CDPH program(s) which may have the personal information) _____ <input type="checkbox"/> 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 a confidential communication.)	

IDENTIFYING INFORMATION IS REQUIRED

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 REQUEST FOR CONFIDENTIAL COMMUNICATION

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 CONFIDENTIAL COMMUNICATION 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 45 CODE OF FEDERAL REGULATIONS, SECTION 164.522(b). 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.