

CONFIDENTIAL**REQUEST FOR ACCESS TO PERSONAL INFORMATION**

NOTE: If you are making this request as the personal representative of another person, (e.g., a minor, a conservatee) please use form CDPH 6237 (Access-Parent, Guardian or Representative) instead of this form.

You have the right to inspect your personal information, which the California Department of Public Health collects, creates or maintains. You also have the right to request copies of those 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 your records mailed, you need to send us 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. 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 INFORMATION				
LAST NAME:		FIRST NAME:		MIDDLE INITIAL:
ADDRESS:		CITY/STATE:		ZIP CODE:
BENEFICIARY ID NUMBER:		DATE OF BIRTH:		
DAYTIME TELEPHONE NUMBER (Required): () _____	EVENING TELEPHONE NUMBER: () _____	EMAIL ADDRESS:	BEST HOURS TO REACH YOU:	
DIRECTIONS				
WHICH CDPH PROGRAM(S) HAS/HAVE THE PERSONAL INFORMATION ABOUT YOU THAT YOU WANT TO ACCESS?				
<input type="checkbox"/> AIDS Drug Assistance Program (ADAP) <input type="checkbox"/> Prenatal Screening Program <input type="checkbox"/> AIDS Medi-Cal Waiver Program (MCWP) <input type="checkbox"/> Prostate Cancer Treatment Program (IMPACT) <input type="checkbox"/> Children's Treatment Program (CTP) <input type="checkbox"/> Therapeutic Monitoring Program (TMP) <input type="checkbox"/> Emergency Medical Services Appropriation (EMSA) <input type="checkbox"/> Viral and Rickettsial Disease Laboratory (VRDL) <input type="checkbox"/> Every Woman Counts (CDS:EWC) <input type="checkbox"/> OTHER (Please list CDPH program(s) which may have your personal information) _____ <input type="checkbox"/> Family Planning Access, Care, & Treatment (FPACT) <input type="checkbox"/> UNKNOWN (If this box is checked, we will call you to assist in determining which CDPH program(s) may have your personal information you are requesting.) <input type="checkbox"/> Newborn Screening Program <input type="checkbox"/> Refugee Health Services				
I AM REQUESTING COPIES OF RECORDS FOR THE FOLLOWING 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.				
<input type="checkbox"/> PLEASE MAIL ME A COPY OF THE REQUESTED INFORMATION. <input type="checkbox"/> I REQUEST THAT A PERSON OF MY CHOOSING BE ALLOWED TO INSPECT THE RECORDS.				
<input type="checkbox"/> I WISH TO REVIEW THE REQUESTED INFORMATION IN PERSON. NOTE: Any person or attorney may be named below. Records will not be sent to photocopy services.				
IF YOU REQUEST TO REVIEW RECORDS IN PERSON, YOU WILL BE CONTACTED TO SCHEDULE AN APPOINTMENT. LOCATION AVAILABLE FOR IN PERSON REVIEW: SACRAMENTO ONLY				
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 INDIVIDUAL'S 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 YOU 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.