

## REQUEST FOR AN ACCOUNTING OF DISCLOSURES OF PROTECTED HEALTH INFORMATION

File Number: \_\_\_\_\_

You have the right to request that the Cancer Detection Section account for the disclosures of your protected health information. You are not entitled to an accounting of disclosures related to treatment, payment, or health care operations; when you have authorized the disclosure; or when the disclosure is to your family, relatives, or others involved in your care. You are also not entitled to an accounting of disclosures for National Security intelligence purposes or to law enforcement officials. You must send us a photocopy of your California driver's license, Department of Motor Vehicles Identification Card, or other valid identification. You may also be required to send documentation verifying your address (see Page 2). Mail this completed form to:

*Cancer Detection Section  
Attention: HIPAA Manager  
MS-7203, P.O. Box 997413  
Sacramento, CA 95899-7413*

INDIVIDUAL INFORMATION			
LAST NAME		FIRST NAME	MIDDLE INITIAL
ADDRESS		CITY/STATE	ZIP CODE
Cancer Detection Programs: Every Woman Counts RECIPIENT ID NUMBER* _____		DATE OF BIRTH _____	SOCIAL SECURITY NUMBER* _____
DAYTIME PHONE NUMBER  (____) _____	ALTERNATE PHONE NUMBER  (____) _____	BEST TIME TO REACH YOU	EMAIL ADDRESS

\*We use these numbers to make sure information goes only to appropriate persons. If you don't supply at least one of the numbers, we will be unable to honor your request. You can get your Recipient ID Number from the place where you received medical services paid for by the Cancer Detection Programs: Every Woman Counts.

**IDENTIFYING INFORMATION** COPY OF PHOTO IDENTIFICATION ATTACHED

ACCEPTABLE IDENTIFICATION IS A CALIFORNIA DRIVER'S LICENSE, CALIFORNIA DMV IDENTIFICATION CARD, PASSPORT, MATRICULA CONSULAR OR STATE OR FEDERAL EMPLOYEE ID CARD.

**I REQUEST THAT THE CALIFORNIA DEPARTMENT OF PUBLIC HEALTH ACCOUNT FOR THE DISCLOSURE OF MY PROTECTED HEALTH INFORMATION.**

FROM: \_\_\_\_\_(MONTH/YEAR) TO: \_\_\_\_\_(MONTH/YEAR)

**I DECLARE UNDER PENALTY OF PERJURY THAT THE INFORMATION ON THIS FORM IS TRUE AND CORRECT.**

SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

 **IF NO PHOTO IDENTIFICATION IS ATTACHED, YOUR SIGNATURE MUST BE NOTARIZED.**

NOTARIZED BY \_\_\_\_\_ ON \_\_\_\_\_ (DATE)

NOTARY PUBLIC NUMBER \_\_\_\_\_

UNOFFICIAL UNLESS STAMPED BY NOTARY PUBLIC

 **IF THE PHOTO IDENTIFICATION DOESN'T SHOW THE ADDRESS ON PAGE 1 OF THIS FORM, PLEASE PROVIDE A PHOTOCOPY OF ONE OF THE FOLLOWING TO CONFIRM YOUR PRESENT ADDRESS: UTILITY BILL, PHONE BILL, DRIVER'S LICENSE, ETC.****NOTE: ANY ATTEMPT TO FALSELY GAIN ACCESS TO PROTECTED HEALTH INFORMATION IS SUBJECT TO LEGAL PENALTIES.**

CDPH is committed to protecting the information you provide us. To prevent unauthorized access or disclosure, to maintain data accuracy, and to ensure the appropriate use of the information, CDPH has in place appropriate physical and managerial procedures to safeguard the information we collect.