CONFIDENTIAL

REQUEST TO AMEND PERSONAL INFORMATION BY PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE

You have the right to request amendments to personal information which the California Department of Public Health creates or maintains. We will act upon your request to amend within 30 days of our receipt of your request. If your request is denied, we will let you know the reasons for the denial in writing. You have the right to disagree with our denial of your request for amendment. You may tell us why in a written statement of disagreement which will be added to your record. If we continue to disagree with your requested amendment, we may place a note (rebuttal statement) in your record on why we do not agree with your statement of disagreement. We will send you a copy of our rebuttal statement. You also have the right, under the Information Practices Act of 1977, to request a review of the refusal to amend a record by the head of the agency or a designee. **Mail, fax or email this completed form**, with a photocopy of your identification and documentation of your address, 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 AMENDING			
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 AMEND THE 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 AUTHORITY 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 AMEND?

- ☐ 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 amending.)

PERSONAL INFORMATION YOU WANT TO AMEND

IDENTIFY THE PERSONAL INFORMATION IN THE INDIVIDUAL'S RECORDS YOU WANT AMENDED:

WHAT YOU WANT THE RECORD TO STATE: (ATTACH ADDITIONAL PAPER IF NECESSARY)

STATE THE REASON YOU BELIEVE THE AMENDMENT NEEDS TO BE MADE:

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 AMENDMENT 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 AMENDMENT 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 SECTIONS 1798.35, 1798.36, AND 1798.37 AND HEALTH & SAFETY CODE SECTION 12311. 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.