

CONFIDENTIAL**REQUEST TO AMEND 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 6239 (Amend-Parent, Guardian or Representative) instead of this form.

You have the right to request amendments to your 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 reason(s) 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 or fax this completed form**, with a photocopy of your identification and documentation of your address, 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 AMEND?

- | | |
|--|---|
| <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"/> Newborn Screening Program | <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 amending.) |
| <input type="checkbox"/> Refugee Health Services | |

PERSONAL INFORMATION YOU WANT TO AMEND

IDENTIFY THE PERSONAL INFORMATION IN YOUR RECORDS YOU WANT AMENDED:

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

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

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 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 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 SECTIONS 1798.35, 1798.36, AND 1798.37 AND HEALTH & SAFETY CODE SECTION 123111. 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.