

1.1 (old 6.1) Confidentiality – Employee and Vendor Responsibility

POLICY:

1. All employees and vendors of the NBS Program (NBSP) in the Genetic Disease Screening Program (GDSP) will adhere to the California Civil Code Division 3, Part 4, Title 1.8, Chapter 1 The Information Practices Act of 1977 (Civil Code Section 1798 et seq.), which states in part:
 - “The Legislature declares that the right to privacy is a personal and fundamental right protected by Section 1 of Article I of the Constitution of California and by the United States Constitution and that all individuals have a right to privacy in information pertaining to them.” (Article 6, Section 1798.1)
 - Article 6, Section 1798.24 of the Information Practice Act describes the circumstances under which disclosures of personal information is allowed.
 - “The term ‘personal information’ means any information that is maintained by an agency that identifies or describes an individual, including, but not limited to, his or her name, social security number, physical description, home address, home telephone number, education, financial matters, and medical or employment history.....” (Article 2, Section 1798.3)
2. All employees and vendors of the NBSP shall adhere to California Statutes of 1995, Chapter 415, Health and Safety Code, Division 104, Part 5, Chapter 1, Article 1, Section 124975(j) which states that “All testing results and personal information from hereditary disorders programs obtained from any individual, or from specimens from any individual, be held confidential and be considered a confidential medical record except for such information as the individual, parent, or guardian consents to be released; provided that the individual is first fully informed of the scope of the information requested to be released, of all of the risks, benefits, and purposes for the release and of the identity of those to whom the information will be released or made available, except for statistical data compiled without reference to the identity of any individual and except for research purposes....”

1.1 Confidentiality – Employee and Vendor Responsibility

3. All employees and vendors shall adhere to Newborn Screening Regulations (Section 6502.1 Confidentiality) and to confidentiality protocols.
4. All employees and staff employed by vendors for the NBSP will sign and adhere to a Security and Confidentiality Acknowledgement form prior to working with the Program (See 1.1.1)
5. Any time that forms (TRF, Result Mailers, etc.) are presented as examples for any purpose, to GDSP or outside staff (where the identifying information is not critical to the work or the situation), names, addresses, zip codes and other identifying information shall be **clearly fictitious** (e.g., Mary Fictitious, No Where Street, CA 99999) or actual patient data shall be "blacked out" or removed. **Actual patient names, addresses and other identifying information shall never be used or visible.**
6. The following HIPAA (Health Insurance Portability and Accountability Act of 1996) requirements and principles will be followed:
 - a. When information is requested by any entity not using the information for treatment, payment and/or health care operations, the minimum necessary information will be communicated from GDSP or ASC staff.
 - b. The staff person handling the request for information will verify the requestor's identity and right to the information requested prior to communicating any information that is considered to be Protected Health Information (PHI). PHI is defined as "individually identifiable health information".
7. In the event of a breach of confidentiality, ASC staff will complete the Breach Incident Reporting Form (See 1.1.2) and send to GDSP NBS Nurse Consultant III/ASC Vendor Liaison.

Associated Forms:

- 1.1.1 Security and Confidentiality Acknowledgement (CDPH 2420 1/11)
- 1.1.2 Breach Incident Reporting Form (CDPH 2375 11/07)

SECURITY AND CONFIDENTIALITY ACKNOWLEDGEMENT

I have read the Information Security Policy (Public Health Administrative Manual (PHAM) Chapter 9-1000) and the Privacy Policy (PHAM Chapter 11-4000), and will comply with the security and privacy requirements indicated in both policies. Also, I understand the need to:

1. Exercise due care to preserve information integrity and confidentiality.
2. Treat passwords as confidential information and do not share them with anyone.
3. Take reasonable precautions to ensure the protection of CDPH information from unauthorized access or destruction.
4. Conduct all Internet and/or E-mail activities in a professional, lawful, and ethical manner, including the use of and development of content for the Internet.
5. Use CDPH information and resources for CDPH business purposes.
6. Download and/or copy only the minimum amount of information required to perform necessary business functions.
7. Encrypt all electronic files that contain Department information when stored on any removable media type device (i.e. USB thumb drives, floppies, CD/DVD, tape backup, etc.)
8. Notify my supervisor and the CDPH Information Security Office of a possible or actual information security incident including, but not limited to:
 - a. Theft, loss, damage, unauthorized destruction, unauthorized modification, misuse, or unintentional or inappropriate release of any CDPH classified data or Protected Health Information (PHI). (Refer to HAM Section 6-1050 for definition of "classified" and "PHI".)
 - b. Inappropriate Use & Unauthorized Access - This includes actions of State employees and/or non-State individuals that involve tampering, interference, damage, or unauthorized access to State computer data and computer systems. Examples are: successful virus attacks, website defacements, server compromises, and denial of service attacks.
 - c. Equipment - Theft, damage, destruction, or loss of State-owned Information Technology (IT) equipment, including mobile computing devices, or any electronic devices containing or storing confidential, sensitive, or personal data.
 - d. Computer Crime - Use of a State information asset in commission of a crime.
 - e. Any other incident that violates the Department's Information Privacy and Security Policy.

Employee name (please print)	
Division	Telephone Number ()
Employee's signature	Date
Supervisor's signature (permitting access)	Date

CDPH BREACH/INCIDENT REPORTING FORM

SECTION A: CONTACT INFORMATION		
REPORTED BY:	PROGRAM:	DATE REPORTED:
TITLE:	TELEPHONE:	
ALTERNATE CONTACT:	EM	AIL:
SECTION B: IDENTIFYING DETAILS WHEN APPLICABLE		
MAKE/MODEL:	SERI	AL NUMBER:
STATE TAG NUMBER:	COMPUTER	NAME:
WAS CONFIDENTIAL DATA INVOLVED, IF SO DESCRIBE:		
WAS DATA ENCRYPTED, DESCRIBE:		
ESTIMATED VALUE OF THE COMPUTING DEVICE:		
SECTION C: INCIDENT DETAILS		
DATE AND TIME OF INCIDENT:		
TYPE OF MEDIA: <input type="checkbox"/> ELECTRONIC <input type="checkbox"/> PAPER		
TYPE OF DEVICE: <input type="checkbox"/> PC <input type="checkbox"/> LAPTOP <input type="checkbox"/> BLACKBERRY/PDA <input type="checkbox"/> CELL PHONE <input type="checkbox"/> OTHER (DVD/CD/UFD)		
CLASSIFICATION OF DATA: <input type="checkbox"/> CONFIDENTIAL <input type="checkbox"/> SENSITIVE <input type="checkbox"/> PERSONAL <input type="checkbox"/> N/A (explain below)		
TYPE OF INCIDENT:		
<input type="checkbox"/> THEFT		
<input type="checkbox"/> LOSS		
<input type="checkbox"/> DAMAGE		
<input type="checkbox"/> DESTRUCTION		
<input type="checkbox"/> MISUSE		
<input type="checkbox"/> UNAUTHORIZED MODIFICATION / RELEASE OF INFORMATION (complete Sections B, D, E)		
DESCRIPTION OF INCIDENT:		
INDIVIDUALS (BENEFICIARIES/EMPLOYEES/CONTRACTORS/ETC.) INVOLVED/AFFECTED BY INCIDENT:		
PROGRAM AREA(S) INVOLVED WITH INCIDENT:		
WERE STATE EMPLOYEES INVOLVED: <input type="checkbox"/> Yes <input type="checkbox"/> No		
LOCATION/ADDRESS OF INCIDENT:		
INCIDENT REPORTED TO (CHP, LAPD, ETC.):		
POLICE REPORT NUMBER:		
HAVE THOSE RESPONSIBLE FOR THE INCIDENT BEEN IDENTIFIED?: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		
IMPACT OF INCIDENT:		
ENTAC CONTACTED: <input type="checkbox"/> Yes <input type="checkbox"/> No	INCIDENT #	OFFICER
ESTIMATED COST OF INCIDENT:		NAMES:

SECTION D: CORRECTIVE ACTIONS

ACTIONS TAKEN TO PREVENT RECURRENCE:

ADDITIONAL RECOMMENDED ACTIONS:

ESTIMATED COST OF CORRECTIVE ACTION: \$

SECTION E: REPORTING SOURCE/ISO SIGNATURE

PREPARER NAME:	TITLE:	TELEPHONE:	
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ISO SIGNATURE	DATE REPORTED:
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AP 1.2 (old 6.2) Confidentiality – Fax and E-Mail Communication of Newborn Screening & and Lab Results

POLICY: Newborn Screening test, Phe Monitoring results, and other protected health information may be faxed and/or e-mailed to the ASC, CCS-Approved Specialty Centers and other health care providers utilizing the following guidelines to protect privacy and ensure patient confidentiality:

FAX

Fax numbers must be double-checked and confirmed with the intended recipient and security of the information being faxed will be discussed with the recipient prior to sending to destination.

The following confidentiality statement must be placed on fax cover sheet:

“NOTE: This Fax and any files transmitted with it are confidential and are intended solely for the use of the individual or entity to whom they are addressed. This communication may contain confidential material protected by the physician-patient privilege. If you are not the intended recipient or the person responsible for delivering the Fax to the intended recipient, be advised that you have received the Fax in error and that any unauthorized use, dissemination, forwarding, printing, or copying of the Fax is strictly prohibited by state and federal laws. If you have received this Fax in error, please immediately notify sender by Fax.”

E-MAIL

Results sent by e-mail will be encrypted whenever possible. From GDSP offices, e-mails can be encrypted by using “[secure]” in the subject line. ASC staff shall use their facility’s secure and/or encrypted e-mail systems when sending confidential information.

- All “TO:” and “CC:” fields must be double-checked before sending to destination.
- The following confidentiality statement must be placed in each e-mail:

“This Email and any files transmitted with it are confidential and are intended solely for the use of the individual or entity to whom they are addressed. This communication may contain confidential material protected by the physician-patient privilege. If you are not the intended recipient or the person responsible for delivering the Email to the intended recipient, be advised that you have received the Email in error and that any unauthorized use, dissemination, forwarding, printing, or copying of the Email is strictly prohibited by state and federal laws. If you have received this Email in error, please immediately notify sender by reply Email.”

- An electronic or hard copy of the e-mail will be retained per the NBSP retention policy.

AP 1.3 (old 6.3) Confidentiality: Release of NBS Results – Policy

POLICY:

1. As specified in the follow-up protocols for each disorder, ASC staff may verbally release NBS results to birth hospitals and physicians for purposes of NBS follow-up. In addition, NBS ASC Coordinators or designee may release results to birth hospitals and physicians providing pediatric care to the child as long as the results are accessible to them in SIS. All other requests must be forwarded to GDSP per *Release of Results - Protocol (6.3-1)*.
2. Results of tests (positive and negative) will be given by GDSP and ASC staff using the requirements in 6.3-1 *Confidentiality: Release of Results - Protocol*.
3. State-generated forms and letters, or forms containing the same elements as state-generated forms, shall be used for processing requests:
4. GDSP and ASC staff must verify the caller/requestor of NBS results (see specific requirements of verification in *Confidentiality: Release of NBS Results (Positive & Negative) - Protocol*).
5. Interpreters must be obtained as needed for those situations where there is a language barrier.
6. When faxing results, GDSP and ASC staff must send to a fax that is confirmed to be secure or ask the requestor for a secure fax number (See: *Confidentiality – Fax and E-Mail Communication of Newborn Screening & Phe Monitoring Results* protocol).
7. Whenever results are released as outlined in 6.3-1 *Confidentiality: Release of NBS Results (Positive and Negative) - Protocol*, they shall be accompanied by a cover letter describing the difference between screening and diagnosis (See 6.3B).
8. Microfiche or duplicate copies of NBS test Results Mailers from March 1982 to July 11, 2005 are maintained in GDSP and can be accessed through the Newborn Screening Program by contacting the appropriate NBSP staff.

NOTE: Prior to May 10, 1999 NBS result mailers (with the exception of the PKU screen) did not report specific values, but were reported only as “positive” or “negative”. If actual results/values are needed, they can be obtained through the Newborn Screening Program by contacting the Nurse Consultant/ASC Vendor Agreement Liaison.

1.3 Confidentiality: Release of Results – Policy

Associated Forms/Documents:

AP 1.3.1 Consent For Disclosure And/Or Release Of Confidential Information From GDSP [PUT LINK](#)

AP 1.3.2 Cover Letter for Release of NBS Results



RON CHAPMAN, MD, MPH
Director

State of California—Health and Human Services Agency
California Department of Public Health



EDMUND G. BROWN JR.
Governor

1.3.2 Cover letter for Release of Results

DATE

Per your request, attached are the Newborn Screening (NBS) results from the California Genetic Disease Screening Program (GDSP).

Please note that these are the results of a screening test. Screening is defined as the testing of a group of people to identify those who are at risk for having a specific disease even though they may seem healthy. This result does not constitute diagnosis or the need for treatment. Therefore, further testing and evaluation by the baby's health care provider or a specialist are needed to make the diagnosis. Please contact your chosen medical or health professional to assist you in reviewing and interpreting these results.

The Newborn screening Program will not identify all newborns with conditions. The possibility of a disorder should never be ruled out solely on the basis of the NBS results. Any signs or symptoms of a disorder should be followed up immediately.

Sincerely,

Erica G. Gordon, MA
Chief, Newborn Screening Clinical Support Branch
Newborn Screening Program

1.4 (old6.4) NBS Dried Blood Spots (DBS) and Identifying Information – Research Use or Restricting Use and Disclosure of

General Information:

1. This protocol includes handling requests for:

- Release of DBS for additional testing
- Destruction of DBS
- Return of DBS to parent
- Family non-contact
- Removal of identifiers from the NBS record
- Prohibiting use of DBS for research
- Prohibiting use of patient Protected Health Information (PHI) for research
- Request for use of DBS in research

2. All newborn screening blood spots since 1982 are stored by the Genetic Disease Laboratory and can be identified and destroyed at the patient's request.

Policy:

1. Requests for obtaining the DBS for additional testing shall be made by using **the Consent for Disclosure and/or Release of Confidential Information from GDSP** or by sending a letter including the same information as in the form.

2. Requests for restricting use and disclosure of NBS Dried Blood Spots and identifying information, and destruction or return of specimens must be in writing and sent to the Chief, Genetic Disease Screening Program (GDSP) in Richmond, CA. The written request may be made by using Attachment *Request to Restrict Use and Disclosure of Personal Information by Parent, Guardian or Personal Representative* form (CDPH Form 6241 (4/09) or by letter. When requests are made by letter, the letter must include the following identifying and request information:

- baby's name
- baby's date of birth
- baby's hospital of birth
- first and last name of baby's mother
- specific information about request, e.g. destroy specimen, return specimen (include where specimen is to be returned), de-identify specimen, etc

6.4 NBS Dried Blood Spots (DBS) and Identifying Information – Research Use or Restricting Use and Disclosure of

3. Requests for use of DBS in research should be directed to Marty Kharrazi, PhD, Research Scientist Supervisor by phone (510-412-1480), e-mail (Marty.Kharrazi@cdph.ca.gov), or with a written request to 850 Marina Bay Pkwy, F-175, Richmond, CA 94804.. Information should include DBS requested, the intended use of the DBS, name of primary researcher and contact information.

Associated Forms:

Consent for Disclosure and/or Release of Confidential Information from GDSP

(<http://www.cdph.ca.gov/programs/nbs/Documents/NBS-Consent%20Release031011pdf>)

Request to Restrict Use and Disclosure of Personal Information by Parent, Guardian or Personal Representative (CDPH Form 6241 (4/09). **NEED to put LINK when we get it**

Protocol:

Resp. Person	Action
Requestor	<ul style="list-style-type: none"> Sends written request, including all pertinent information to Chief of GDSP (See Policy # 1 and 2 above) or to Research Scientist Supervisor (See Policy #3 above).
Chief, GDSP	<ul style="list-style-type: none"> Forwards written requests for release of DBS for additional testing to GDSP Assistant Chief, Administrative Support Forwards written requests for all other restrictions of use of DBS and identifying information to designated (Program Development and Evaluation Branch (PDEB) research scientist to process.
GDSP Assistant Chief, Administrative Support OR Research Scientist Supervisor	<ul style="list-style-type: none"> Processes requests.

CONFIDENTIAL**REQUEST TO RESTRICT USE AND DISCLOSURE OF PERSONAL INFORMATION BY
PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE**

You have the right to request the California Department of Public Health Services (CDPH) to restrict the use and disclosure personal information to carry out treatment, payment or operations. You also have the right to request CDPH not to disclose personal information to a family member, relative, or friend involved with care or payment for the individual's health care. NOTE: CDPH may refuse to agree to your requested restriction(s) but will notify you of its refusal in its response to your request. This form must be accompanied by 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 (see below). **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 WHOSE INFORMATION YOU ARE REQUESTING TO RESTRICT THE USE AND DISCLOSURE OF PERSONAL INFORMATION				
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 RESTRICT THE USE AND DISCLOSURE OF PERSONAL INFORMATION ABOUT THE INDIVIDUAL LISTED ABOVE?				
<input type="checkbox"/> PARENT		<input type="checkbox"/> CONSERVATOR		
<input type="checkbox"/> GUARDIAN		<input type="checkbox"/> EXECUTOR OF WILL		
<input type="checkbox"/> MEDICAL POWER OF ATTORNEY		<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) HAS/HAVE THE PERSONAL INFORMATION OF THE INDIVIDUAL ABOVE THAT YOU WANT TO RESTRICT USE AND DISCLOSURE OF?				
<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 the 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 the personal information you are requesting we restrict the use and disclosure.)		
<input type="checkbox"/> Refugee Health Services				

CHECK ALL THAT APPLY

I REQUEST THAT THE CALIFORNIA DEPARTMENT OF PUBLIC HEALTH RESTRICT USE AND DISCLOSURE OF THE INDIVIDUAL'S PERSONAL INFORMATION IN CARRYING OUT TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS AS FOLLOWS:

I REQUEST THAT THE CALIFORNIA DEPARTMENT OF PUBLIC HEALTH RESTRICT THE DISCLOSURE OF PERSONAL INFORMATION FROM THE FOLLOWING PERSONS:

PLEASE PROVIDE THE NAMES OF ANY FAMILY MEMBERS, RELATIVES... TO WHOM YOU DO NOT WANT CDPH TO DISCLOSE INFORMATION IN THE SPACE ABOVE.

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.

REPRESENTATIVE SIGNATURE: _____ DATE: _____

DEPARTMENT EMPLOYEE PROCESSING/MAINTAINING THIS REQUEST FOR RESTRICTION ON USE AND DISCLOSURE OF PERSONAL INFORMATION

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 TO RESTRICT USE AND DISCLOSURE 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 TITLE 45, CODE OF FEDERAL REGULATIONS, SECTION 164.522. 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.