

# REQUEST TO AMEND PROTECTED HEALTH INFORMATION BY PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE

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

You have the right to request amendments to protected health information which Medi-Cal 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 that 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 this completed form, with a photocopy of your identification and documentation of your address, to:

Department of Health Care Services  
EDS Communications  
P.O. Box 526018  
Sacramento, CA 95852-6018

<b>INDIVIDUAL WHOSE INFORMATION YOU ARE AMENDING</b>				
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				
<b>PARENT, GUARDIAN, OR PERSONAL REPRESENTATIVE INFORMATION</b>				
LAST NAME:		FIRST NAME:		MIDDLE INITIAL:
ADDRESS:		CITY/STATE:		ZIP CODE:
DAYTIME TELEPHONE NUMBER: ( )	EVENING TELEPHONE NUMBER: ( )		EMAIL ADDRESS:	BEST HOURS TO REACH YOU:

**WHAT LEGAL AUTHORITY DO YOU HAVE TO AMEND THE HEALTH INFORMATION OF THE INDIVIDUAL ABOVE?**

- PARENT  CONSERVATOR  
 GUARDIAN  EXECUTOR OF WILL  
 MEDICAL POWER OF ATTORNEY  OTHER

PLEASE ATTACH LEGAL DOCUMENTATION VERIFYING THAT YOU ARE THE PARENT, CONSERVATOR, GUARDIAN, EXECUTOR OF A DECEDENT'S WILL, OR HAVE MEDICAL DECISION-MAKING AUTHORITY FOR THE INDIVIDUAL.

**PROTECTED HEALTH INFORMATION YOU WANT TO AMEND**

IDENTIFY THE PROTECTED HEALTH INFORMATION IN THE INDIVIDUAL'S MEDICAL RECORD 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:

**IDENTIFYING INFORMATION**

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: \_\_\_\_\_

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

REPRESENTATIVE SIGNATURE:

DATE:

**(IF NO IDENTIFICATION IS ATTACHED YOUR SIGNATURE MUST BE NOTARIZED.)**

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

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

UNOFFICIAL UNLESS STAMPED BY NOTARY PUBLIC:

ADDRESS VERIFICATION ATTACHED

FORM OF ADDRESS VERIFICATION \_\_\_\_\_ (UTILITY BILL, PHONE BILL, DRIVER'S LICENSE, ETC.)

**NOTE: ANY ATTEMPT TO FALSELY GAIN ACCESS TO PROTECTED HEALTH INFORMATION IS SUBJECT TO LEGAL PENALTIES.**