

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

File Number: _____

You have the right to request amendments to protected health information which the Department of Health Care Services, California Children's Services (CCS) program 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:

Attention: HIPAA Representative
Department of Health Care Services
Children's Medical Services Branch
Genetically Handicapped Persons Program
1515 K Street, Room 400
P.O. Box 997413, MS 8100
Sacramento, CA 95899-7413
(800) 639-0597

CLIENT WHOSE INFORMATION YOU ARE AMENDING		
LAST NAME:	FIRST NAME:	MIDDLE INITIAL:
ADDRESS:	CITY/STATE:	ZIP CODE:
CLIENT INDEX NUMBER (CIN):	DATE OF BIRTH:	DATE OF DEATH: (IF APPLICABLE)
DEATH CERTIFICATE MUST BE ATTACHED		
PARENT, GUARDIAN, OR LEGAL REPRESENTATIVE INFORMATION		
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 CLIENT 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			
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 CLIENT.			
PROTECTED HEALTH INFORMATION YOU WANT TO AMEND			
IDENTIFY THE PROTECTED HEALTH INFORMATION IN THE CLIENT'S CCS RECORD 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:

IDENTIFY THE PERSON(S) TO WHOM YOU WANT THE CCS PROGRAM TO SEND THE PHI AMENDMENT(S). PROVIDE FULL NAME, ADDRESS, AND ZIP CODE. UPON APPROVAL, AMENDMENT(S) WILL BE SENT TO PERSON(S) IDENTIFIED, AND TO PROVIDERS, HEALTH PLANS, AND OTHER BUSINESS ASSOCIATES OF CCS PREVIOUSLY SENT THE CLIENT'S PHI.

IDENTIFYING INFORMATION

COPY OF IDENTIFICATION ATTACHED

TYPE: _____ (CA DRIVER'S LICENSE, CA DMV IDENTIFICATION CARD, STATE OR FEDERAL EMPLOYEE ID CARD)

NUMBER: _____

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

LEGAL 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.