JENNIFER KENT
DIRECTOR

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

EDMUND G. BROWN JR.
GOVERNOR

REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION (DHCS 6236)

File Number: _________________

You have the right to inspect your protected health information in records, which Medi-Cal creates or maintains. You also have the right to request copies of those records. You will receive a response to your request within 30 days after we receive your request. If you want copies of your records mailed, you need to send us a photocopy of your California driver's license, Department of Motor Vehicles Identification Card, or other valid identification. You will also need to send documentation verifying your address. **Mail this completed form to address below:**

Department of Health Care
Services DHCS/MEDI-CAL FI
P. O. Box 526018
Sacramento, CA 95852-6018
(916) 636-1980

Directions

Please read the following before completing this form. If any of the circumstances below applies to you, you may not need to fill out this form.

You have a personal injury case and Medi-Cal has paid for services related to the injury and you want information about these services and/or payments.

or

You are requesting access to records on behalf of a deceased Medi-Cal beneficiary in order to repay Medi-Cal for services received by the deceased beneficiary. You may have received an Estate Recovery Questionnaire in the mail.

or

You are involved in a worker's compensation case in which Medi-Cal has paid for services for the injury you received while on the job.

Please call (916) 650-0490 for further information about these circustances .
If none of these circumstances apply, please complete the form.

Your Information		
Last Name:	First Name:	Middle Initial:
Address:	City/State:	Zip Code:
Benefits ID Number:	Date of Birth:	
Telephone Number:	E-mail Address:	

Description of the Specific Information to be Released/Inspected

Check each type of confidential information you authorize to be released/inspected:

- ☐ HIV or AIDS Information
- ☐ Alcohol/Drug Information
- ☐ Mental Health/Behavioral Health Information
- ☐ Genetic Testing

Other:

Information from the categories above will be authorized for the following period of time: from______________ (date) to______________ (date).

DHCS

Check Each Type of Protected Information You Want to Access:

☐ **Claim Detail Reports**, which contain claims paid by Medi-Cal for services received.

☐ **Treatment Authorization Request Screens**. Printouts contain patient names, which providers have requested services, which services were requested, the decision about the service(s), including a simple description of the decision, and whether the provider has billed for these services.

☐ **Case Management Records**, which contain case manager notes.

Managed Care Records:

☐ Enrollment Records
☐ Disenrollment Records
☐ Capitation Paid to Health Plan
☐ MERS Fair Hearing Documentation

Denti-Cal Records:
Call (800) 322-6384

Please contact your care provider or managed care plan if you want access to your medical records.

I am requesting copies of records for the following dates of service:
You must specify dates of service in order to get records.

From Date (month/day/year) **To Date** (month/day/year)

Please note: A request for records of services provided up to six years ago is a 30-day process. All other requests have an approximate 60-day time frame for additional processing.

☐ Please mail me a copy of the requested information.

☐ I wish to review the requested information in person.

If you request to review records in person, you will be contacted to schedule an appointment. Location available for in person review: **Sacramento Only**

Requestor's Identifying Information:

☐ 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.

This authorization for release of the above information to the above named persons or organizations will expire on: ______ (specific date).

I understand that by signing this authorization:

- I authorize the use and/or disclosure of my individually identifiable health information at the request of the patient (myself). I understand that this authorization is voluntary.
- My treatment, payment, enrollment or eligibility for benefits will not be affected if I do not sign this authorization.
- Health Information disclosed through the authorization may be subject to re-disclosure and is no longer protected if it is disclosed to anyone other than a covered entity.
- I have the right to receive a copy of this authorization.
- Records and copies obtained relating to outpatient psychotherapy care shall be returned or destroyed at the expiration date of this authorization except those obtained for treatment and diagnosis purposes.

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

Member Signature:	Date: