STATE OF CALIFORNIA-Health and Human Services Agency Department of Health Services

 Office of HIPAA Compliance

**Request for an Accounting of Disclosures**

**OF PROTECTED HEALTH INFORMATION**

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

You have the right to request the California Department of Health Services, California Children’s Services (CCS) program to account for the disclosures of your protected health information. You are not entitled to an accounting of disclosures to carry out treatment, payment, or health care operations; when you have authorized the disclosure; or when the disclosure is to your family, relatives, or others involved in your care. You are also not entitled to an accounting of disclosures for National Security or intelligence purposes and to law enforcement officials. A photocopy of your identification and documentation of your address must accompany this form. Mail this completed form to:

Attention: HIPAA Representative

California Department of Health Services

Children’s Medical Services Branch

California Children’s Services

Northern California Regional Office/ San Francisco

575 Market Street, Suite 300

San Francisco, CA 94105

(415) 904-9699

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| --- |
| CLIENT INFORMATION |
| LAST NAME:      | FIRST NAME:      | MIDDLE INITIAL:      |
| ADDRESS:      | CITY/STATE:      | ZIP CODE:      |
| CLIENT INDEX NUMBER (CIN): | DATE OF BIRTH: |  |
| DAYTIME TELEPHONE NUMBER:(     ) | EVENING TELEPHONE NUMBER:(     ) | EMAIL ADDRESS:      | BEST HOURS TO REACH YOU:      |
| IDENTIFYING INFORMATION |
| [ ]  COPY OF IDENTIFICATION ATTACHEDTYPE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (CA DRIVER’S LICENSE, CA DMV IDENTIFICATION CARD, STATE OR FEDERAL EMPLOYEE ID CARD)NUMBER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **I REQUEST THAT THE DEPARTMENT OF HEALTH SERVICES ACCOUNT FOR THE DISCLOSURE OF MY PROTECTED HEALTH INFORMATION.** FROM: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(MONTH/YEAR) TO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(MONTH/YEAR)**I DECLARE UNDER PENALTY OF PERJURY THAT THE INFORMATION ON THIS FORM IS TRUE AND CORRECT.**CLIENT 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 ATTACHEDFORM 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.**