

**County/Direct Provider Approver Certification****DHCS Approved** (DHCS use only)**Date** \_\_\_\_\_ **Approver** \_\_\_\_\_

For Access to Confidential DHCS Drug Medi-Cal Information Data

**County:** \_\_\_\_\_  
(County Name and Code)**Direct Provider:** \_\_\_\_\_  
(Direct Provider Name and Four Digit DMC Number(s))

To ensure the confidentiality of county/direct provider Drug Medi-Cal (DMC) data, the Department of Health Care Services (DHCS) requests the County AOD Administrator or Direct Provider Executive Officer designate a primary and a secondary contact to be responsible for approving county/direct provider staff requests for access to confidential patient data in the Short-Doyle/Medi-Cal Claims system. Please complete the information below and fax this form to (916) 323-0653. If you have questions about this form, please call (916) 323-2043.

**Primary Approver:**

First Name: _____	Last Name: _____
Title: _____	
Phone Number: ( ) _____	Fax Number: : ( ) _____
Email Address: _____	
Primary Approver's Signature: _____	
<small>(Signer acknowledges having read the attached Confidentiality Statement for all DHCS AOD users of the ITWS)</small>	

**Secondary Approver:**

First Name: _____	Last Name: _____
Title: _____	
Phone Number: ( ) _____	Fax Number: : ( ) _____
Email Address: _____	
Secondary Approver's Signature: _____	
<small>(Signer acknowledges having read the attached Confidentiality Statement for all DHCS AOD users of the ITWS)</small>	

**Appointed Vendor(s): (If applicable)**

The vendor listed below has the authority to receive, send and process the above named county/direct provider's confidential DHCS Drug Medi-Cal information in the Short-Doyle / Medi-Cal Claims system. The vendor will establish its own primary and secondary approving contacts.	
Vendor Name: _____	
Vendor Contact Name: _____	Phone Number: ( ) _____

**DHCS AOD Administrator/Executive Officer Certification:**

As the AOD Administrator or Executive Officer for \_\_\_\_\_ (County/Direct Provider), I designate the above individuals and vendor, if applicable, to have independent authority to approve access requests to specific confidential Drug Medi-Cal patient data. DHCS may rely on approvals, denials, and changes made by the above individuals/vendor in its processing of access requests to this county/direct provider's data in the systems listed above. As changes occur to the above approving contacts or vendor information (name, phone, e-mail, or fax), I will sign an updated certification and forward it to DHCS. Also, I acknowledge reading the Confidentiality Statement for all DHCS AOD users of the ITWS.

DHCS AOD Administrator/Executive Officer (signed and printed)

Date