

**County/Direct Provider User Cancellation**

<b>DHCS Approved</b> (DHCS Use Only)	
<u>Date</u>	<u>Approver</u>

For Canceling User Access to Confidential DHCS Drug Medi-Cal

**County/Direct Provider/Vendor:** \_\_\_\_\_

To ensure the confidentiality of county/direct provider Drug Medi-Cal (DMC) data, the Department of Health Care Services (DHCS) requests the County DHCS AOD Administrator, Direct Provider Executive Officer or Vendor Executive Officer to notify DHCS when previously approved users should no longer be allowed access to confidential patient data in the system listed below. 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.

**User No Longer Authorized Access as of** \_\_\_\_\_ **(Date)**

First Name: _____	Last Name: _____
Username: _____	
Phone Number: _____	Fax Number: _____
Email Address: _____	

**User No Longer Authorized Access as of** \_\_\_\_\_ **(Date)**

First Name: _____	Last Name: _____
Username: _____	
Phone Number: _____	Fax Number: _____
Email Address: _____	

**User No Longer Authorized Access as of** \_\_\_\_\_ **(Date)**

First Name: _____	Last Name: _____
Username: _____	
Phone Number: _____	Fax Number: _____
Email Address: _____	

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

As AOD Administrator/Executive Officer for \_\_\_\_\_ (County/Direct Provider/Vendor), I designate the above individual(s) no longer has/have access requests to specific confidential Drug Medi-Cal patient data.

\_\_\_\_\_  
DHCS AOD Administrator/Executive Officer (signed and printed)

\_\_\_\_\_  
Date