State of California — Health and Human Services Agency

Department of Health Care Services
CalOMS
MS 2603
PO Box 997413
Sacramento, CA 95899-7413

CalOMS ITWS County/Direct Provider/Vendor User Cancellation

For Canceling User Access to the CalOMS Treatment Data System

DHCS Approved	
Date	Approver

County or Direct Provider or Vendor **Name**: _____

County or Direct Provider or Vendor **Number**: _____

To ensure the confidentiality of county/direct provider CalOMS Treatment data, the Department of Health Care Services (DHCS) requires that the County Alcohol and Drug Program Administrator or Direct Provider/Vendor Executive Officer notify DHCS when previously-approved users should no longer be allowed access to confidential patient data in the CalOMS Treatment data system. Please complete and fax this form to DHCS at (916) 322-7117. If you have questions about this form, please call (916) 327-3010 or e-mail CalOMSHelp@DHCS.ca.gov **Please print all information**

First Name: _____ Last Name: _____

Username: _____

Phone Number: (____) _____ Fax Number: : (____) _____

Email Address: _____

User no longer authorized access as of _____(date) to the CalOMS Treatment data system.

First Name: _____ Last Name: _____

Username: _____

Phone Number: (____) _____ Fax Number: : (____) _____

Email Address: _____

User no longer authorized access as of _____(date) to the CalOMS Treatment data system.

First Name: _____ Last Name: _____

Username: _____

Phone Number: (____) _____ Fax Number: : (____) _____

Email Address: _____

User no longer authorized access as of _____(date) to the CalOMS Treatment data system.

County AOD Administrator/Direct Provider or Vendor Executive Officer:

I hereby designate that the above-named individual(s) no longer has access rights to confidential patient data in the CalOMS Treatment data system

_____ _____

Administrator/Executive Officer (signed and printed) Date