REQUEST TO AMEND
PROTECTED HEALTH INFORMATION

File Number: _____

You have the right to request amendments to your protected health information which Medi-Cal creates or maintains. We will act upon your request to amend within 30 days of our receipt of your request. If your request is denied, we will let you know the reasons for the denial in writing. You have the right to disagree with our denial of your request for amendment. You may tell us why in a written statement of disagreement that will be added to your record. If we continue to disagree with your requested amendment, we may place a note (rebuttal statement) in your record on why we do not agree with your statement of disagreement. We will send you a copy of our rebuttal statement. You also have the right, under the Information Practices Act of 1977, to request a review of the refusal to amend a record by the head of the agency or a designee. Mail this completed form, with a photocopy of your identification and documentation of your address, to:

Department of Health Care Services
EDS Communications
P.O. Box 526018
Sacramento, CA 95852-6018

<table>
<tr><th colspan="4">INDIVIDUAL INFORMATION</th></tr>
<tr><td colspan="2">LAST NAME:</td><td>FIRST NAME:</td><td>MIDDLE INITIAL:</td></tr>
<tr><td colspan="2">ADDRESS:</td><td>CITY/STATE:</td><td>ZIP CODE:</td></tr>
<tr><td colspan="2">BENEFICIARY ID NUMBER:</td><td colspan="2">DATE OF BIRTH:</td></tr>
<tr><td>DAYTIME TELEPHONE NUMBER:

( )</td><td>EVENING TELEPHONE NUMBER:

( )</td><td>EMAIL ADDRESS:</td><td>BEST HOURS TO REACH YOU:</td></tr>
<tr><th colspan="4">PROTECTED HEALTH INFORMATION YOU WANT TO AMEND</th></tr>
<tr><td colspan="4">IDENTIFY THE PROTECTED HEALTH INFORMATION IN YOUR MEDI-CAL RECORD YOU WANT AMENDED:</td></tr>
</table>

WHAT YOU WANT THE RECORD TO STATE NOW: (ATTACH ADDITIONAL PAPER IF NECESSARY)

STATE THE REASON YOU BELIEVE THE AMENDMENT NEEDS TO BE MADE:

IDENTIFYING INFORMATION

☐ 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:_____

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

BENEFICIARY 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 ATTACHED

FORM 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.