CONFIDENTIAL COMMUNICATION REQUEST

File Number: _____

You or your legal representative may request the Department of Health Care Services to contact you at another address or telephone number, other than what is currently in your California Children's Services (CCS) records, or by a different method (such as only by mail or only by telephone). To request this, mail this completed form to:

Attention: HIPAA Representative
Department of Health Care Services
Children's Medical Services Branch
California Children's Services
Northern California Regional Office
575 Market Street, Suite 300
San Francisco, CA 94105
(415) 904-9699

<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">CURRENT ADDRESS:</td><td>CITY/STATE:</td><td>ZIP CODE:</td></tr>
<tr><td colspan="2">CLIENT INDEX NUMBER (CIN)</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><td colspan="4">I REQUEST THAT THE DEPARTMENT OF HEALTH CARE SERVICES CONTACT ME AT A DIFFERENT ADDRESS AND/OR A DIFFERENT TELEPHONE NUMBER THAN WHAT IS LISTED IN MY CCS RECORDS BECAUSE CONTACTING ME AT MY CURRENT ADDRESS AND/OR TELEPHONE NUMBER IS A SAFETY ISSUE FOR ME.</td></tr>
<tr><td colspan="4">ALTERNATE STREET ADDRESS OR POST OFFICE BOX TO CONTACT ME</td></tr>
<tr><td colspan="3">CITY, STATE</td><td>ZIP CODE</td></tr>
<tr><td colspan="4">ALTERNATE TELEPHONE NUMBER TO CONTACT ME
( )</td></tr>
<tr><td colspan="4">I MAY ALSO REQUEST THE DEPARTMENT OF HEALTH CARE SERVICES TO LIMIT THE WAY IT CONTACTS ME.</td></tr>
</table>

I REQUEST THAT THE DEPARTMENT OF HEALTH CARE SERVICES CONTACT ME

☐ ONLY BY TELEPHONE ☐ ONLY BY MAIL (PLEASE CHECK ONE)

IDENTIFYING INFORMATION

☐ COPY OF IDENTIFICATION ATTACHED

TYPE_____ (CA DRIVER'S LICENSE, CA DMV IDENTIFICATION CARD, BIRTH CERTIFICATE, BENEFICIARY 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.