REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

File Number: _____

You have the right to request to inspect your protected health information in records which the Department of Health Care Services, California Children's Services (CCS) program, creates or maintains. You also have the right to request copies of those records. You will be charged for the cost of copying and postage. You will receive a response to your request within 30 days after we receive your request. If you want copies of your records mailed, you need to send us a photocopy of your California driver's license, Department of Motor Vehicles Identification Card, or other valid identification. You will also need to send documentation verifying your address. 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/San Francisco
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">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><th colspan="4">PROTECTED HEALTH INFORMATION YOU WANT TO ACCESS</th></tr>
<tr><td colspan="4">WHAT TYPE OF PROTECTED HEALTH INFORMATION DO YOU WANT TO ACCESS?</td></tr>
<tr><td colspan="4">☐ PROGRAM APPLICATION
☐ PROGRAM SERVICE AGREEMENT
☐ SERVICE AUTHORIZATION REQUEST
☐ SERVICE AUTHORIZATIONS
☐ DENIALS
☐ NOTICE OF ACTION
☐ FINANCIAL ELIGIBILITY
☐ RESIDENTIAL ELIGIBILITY
☐ NARRATIVES
☐ OTHER, SPECIFY _____
_____</td></tr>
</table>

PLEASE BE SPECIFIC AS YOU WILL BE CHARGED FOR EACH PAGE COPIED.

FOR WHAT TIME PERIOD DO YOU WANT INFORMATION?

FROM DATE	TO DATE

METHOD TO ACCESS YOUR PROTECTED HEALTH INFORMATION

☐ PLEASE MAIL ME A COPY OF THE REQUESTED INFORMATION TO THE ADDRESS INDICATED ON PAGE ONE OF THIS FORM.

☐ I WISH TO REVIEW THE REQUESTED INFORMATION IN PERSON.

☐ I REQUEST INTERPRETATION SERVICES

☐ I REQUEST THAT A PERSON OF MY CHOOSING BE ALLOWED TO INSPECT MY RECORDS.

NAME

TELEPHONE NUMBER ( )

ADDRESS

RELATIONSHIP TO YOU

IF YOU REQUEST TO REVIEW RECORDS IN PERSON YOU WILL BE CONTACTED TO SCHEDULE AN APPOINTMENT.

LOCATION OPTION

Attention: HIPAA Representative
Department of Health Care Services
Children's Medical Services Branch
California Children's Services
Northern California Regional Office/San Francisco
575 Market Street, Suite 300
San Francisco, CA 94105
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IDENTIFYING INFORMATION

☐ COPY OF IDENTIFICATION ATTACHED

TYPE_____ (CA DRIVER'S LICENSE, CA DMV IDENTIFICATION CARD, STATE OR FEDERAL EMPLOYEE ID CARD)

NUMBER_____

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

CLIENT 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.