REQUEST TO RESTRICT USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

File Number: ____________________

You have the right to request the Department of Health Care Services (DHCS) to restrict the use and disclosure of your California Children's Services (CCS) protected health information to carry out treatment, payment or operations. You also have the right to request DHCS not to disclose CCS protected health information to a family member, relative, or friend involved with your care or payment for your health care. DHCS may not be able to agree with your request. This form must be accompanied by a photocopy of a form of identification and documentation of 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

CLIENT INFORMATION			
LAST NAME:		FIRST NAME:	MIDDLE INITIAL:
ADDRESS:		CITY/STATE:	ZIP CODE:
CLIENT INDEX NUMBER (CIN):		DATE OF BIRTH:	
DAYTIME TELEPHONE NUMBER: ( )	EVENING TELEPHONE NUMBER: ( )	EMAIL ADDRESS:	BEST HOURS TO REACH YOU:
CHECK ALL THAT APPLY			

☐ **I REQUEST THAT THE DEPARTMENT OF HEALTH CARE SERVICES RESTRICT USE AND DISCLOSURE OF MY CCS PROTECTED HEALTH INFORMATION IN CARRYING OUT TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS AS FOLLOWS:**

☐ **I REQUEST THAT THE DEPARTMENT OF HEALTH CARE SERVICES RESTRICT THE USE AND DISCLOSURE OF THE CCS PROTECTED HEALTH INFORMATION TO THE FOLLOWING PERSONS:**

[PLEASE PROVIDE THE NAMES AND RELATIONSHIP OF ANY FAMILY MEMBERS, RELATIVES, OR OTHER IDENTIFIED PERSONS TO WHOM YOU DO NOT WANT DHCS TO DISCLOSE INFORMATION.]

IDENTIFYING INFORMATION

☐ COPY OF IDENTIFICATION ATTACHED

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

NUMBER:_________________________

I UNDERSTAND THE DEPARTMENT OF HEALTH CARE SERVICES MAY NOT AGREE TO REQUESTED RESTRICTION(S), BUT WILL NOTIFY ME OF ITS RESPONSE TO MY REQUEST.

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.)