REQUEST TO RESTRICT USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION BY PARENT, GUARDIAN OR LEGAL REPRESENTATIVE

File Number: _____

You have the right to request the Department of Health Care Services (DHCS) to restrict the use and disclosure of the 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 the care or payment of the individual's 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 FOR WHOM YOU ARE REQUESTING TO RESTRICT THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION		
LAST NAME:	FIRST NAME:	MIDDLE INITIAL:
ADDRESS:	CITY/STATE:	ZIP CODE:
CLIENT INDEX NUMBER (CIN):	DATE OF BIRTH:	DATE OF DEATH: (If Applicable)
DEATH CERTIFICATE MUST BE ATTACHED		

PARENT, GUARDIAN, OR LEGAL REPRESENTATIVE INFORMATION		
LAST NAME:	FIRST NAME:	MIDDLE INITIAL**:**
ADDRESS:	CITY/STATE:	ZIP CODE:

DAYTIME TELEPHONE NUMBER: ( )	EVENING TELEPHONE NUMBER: ( )	EMAIL ADDRESS:	BEST HOURS TO REACH YOU:

WHAT LEGAL AUTHORITY DO YOU HAVE TO RESTRICT THE HEALTH INFORMATION OF THE CLIENT ABOVE?

☐ PARENT ☐ CONSERVATOR

☐ GUARDIAN ☐ EXECUTOR OF WILL

☐ MEDICAL POWER OF ATTORNEY ☐ OTHER

PLEASE ATTACH LEGAL DOCUMENTATION VERIFYING THAT YOU ARE THE PARENT, CONSERVATOR, GUARDIAN, EXECUTOR OF A DECEDENT'S WILL, OR HAVE MEDICAL DECISION-MAKING AUTHORITY FOR THE CLIENT.

CHECK ALL THAT APPLY

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

☐ **I REQUEST THAT DEPARTMENT OF HEALTH CARE SERVICES RESTRICT THE USE AND DISCLOSURE OF 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.

LEGAL REPRESENTATIVE 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.)