AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

File Number: ________________

You have the right to inspect your protected health information in records, which Medi-Cal creates or maintains. You also have the right to request copies of those records. 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 address below:**

Department of Health Care Services
DHCS/MEDI-CAL FI
P.O. Box 526018
Sacramento, CA 95852-6018
(916) 636-1980

Directions

Please read the following before completing this form. If any of the circumstances below applies to you, you may not need to fill out this form.

You have a personal injury case and Medi-Cal has paid for services related to the injury and you want information about these services and/or payments.

Or

You are requesting access to records on behalf of a deceased Medi-Cal beneficiary in order to repay Medi-Cal for services received by the deceased beneficiary. You may have received an Estate Recovery Questionnaire in the mail.

Or

You are involved in a worker's compensation case in which Medi-Cal has paid for services for the injury you received while on the job.

Please call (916) 650-0490 for further information about these circumstances.

If none of these circumstances apply, please complete the form.

A. Whose Information is Being Requested?		
Last Name:	First Name:	Middle Initial:
Address:	City/State:	Zip Code:
Benefits ID Number:	Date of Birth:	
Telephone Number:	E-mail Address:	

B. Requestor's Information ***Please state your (the requestor's) information below. This includes third party requestors such as a parent, guardian, personal representative or other legally authorized third party.***		
Last Name:	First Name:	Middle Initial:
Address:	City/State:	Zip Code:
Benefits ID Number:	Date of Birth:	
Telephone Number:	E-mail Address:	

What Legal Authority Do You Have to Request Health Information	
☐ Self **(Note: If you are requesting your own records, please check this box.)**	☐ Conservator
☐ Parent of a minor	☐ Executor of will

☐ Guardian	☐ Administrator of estate
☐ Conservator	
☐ Other: ______________________________	
Note: You Must Attach Legal Documentation to Verify That You Are the Parent, Conservator, Guardian, Executor of a Decedent's Will, or Have Medical Decision-Making Authority for the Individual.	

C. Description of the Specific Information to be Released/Inspected

Check each type of confidential information you authorize to be released/inspected:	
☐ HIV or AIDS	☐ Alcohol/Drug Information
☐ Mental Health/Behavioral	☐ Health Genetic Testing
Other:	
Information from the categories above will be authorized for the following period of time: from_____________ (date) to_____________ (date).	

D. Check Each Type of Protected Information You Want to Access:	
☐ **Claim Detail Reports**, which contain claims paid by DHCS for services received.	**Managed Care Records:** ☐ Enrollment Records ☐ Disenrollment Records ☐ Capitation Paid to Health Plan ☐ MERS Fair Hearing Documentation
☐ **Medi-Cal Eligibility Verification Printouts,** which contains information regarding the eligibility status of an Medi-Cal member over a designated time period.	
☐ **Treatment/Service Authorization Request Screens**. Printouts contain the names of individuals, which providers have requested services for those individuals, which services were requested, the decision about the service(s), including a simple description of the decision, and whether the provider has billed for these services.	**For Denti-Cal Treatment/Service Authorization Request Screens:** Call (800) 322-6384
	☐ **Genetically Handicapped Persons Program (GHPP) and/or California Children's Services (CCS) Records.**
☐ **Case Management Records**, which contain case manager notes.	*Please contact your care provider or managed care plan if you want access to your medical records.*

I am requesting copies of records for the following dates:

You must specify dates for DHCS to be able to provide responsive records.

From Date (month/day/year) ______________________

To Date (month/day/year) ______________________

E. Description of the Purpose and Limitations for the Release or Inspection of the Information (Indicate How Information Will Be Used).

Please note that the statement "at my request", or other similar language that indicates your intent, is a sufficient description.

The information will not be used for any purpose other than its intended use.

F. How would you like to receive the requested information?

Please note: A request for records going back up to six years old generally takes 30 days to process. All other requests have an approximate 60-day time frame because of additional processing.

☐ Please mail me a copy of the requested information.

☐ I wish to review the requested information in person.

If you request to review records in person, you will be contacted to schedule an appointment. Location available for in person review: **Sacramento Only**

☐ Please mail a copy of the requested information to the following third party:

Name: ___________________________________

Organization (if applicable): _____________________________

Position or Role at Organization (if applicable): ___________________________

If organization and position or role at organization are blank:

If you are requesting your own information, recipient's relationship to you _______; or

If you are a third party requesting an individual's information, recipient's relationship to the individual: ________________

Address: _________________________________

City/State/ZIP: ___________________________

Telephone Number: _______________________

Email Address: ____________________________

☐ I Request That a Person of My Choosing be Allowed to Inspect My Records. **Note:** Any person or attorney may be named below.

Name: ________________________________

Organization (if applicable): __________________________

Position or Role at Organization (if applicable): ________________________

If organization and position or role at organization are blank:

If you are requesting your own information, recipient's relationship to you _______; or

If you are a third party requesting an individual's information, recipient's relationship to the individual: _______________

Address: ______________________________

City/State/ZIP: _________________________

Telephone Number: _____________________

Email Address: _________________________

G. Requestor's Identifying Information:

☐ Address verification attached

Type: _________________________ (Utility Bill, Phone Bill, Driver's License, Etc.)

☐ 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: _______________________

(IF NO IDENTIFICATION IS ATTACHED, YOUR SIGNATURE MUST BE NOTARIZED)

Notarized By ______________________________ On ________________ (Date).

Notary Public Number:____________________________

UNOFFICIAL UNLESS STAMPED BY NOTARY PUBLIC:

This authorization for release of the above information to the above named persons or organizations will expire on: ____________ (date)

H. Requestor's Understanding of the Authorization to Release Information

I understand that by signing this authorization:
• This authorization for release of the above information to the above-named person(s) or organization(s) will expire on: ____________ (date)
• I authorize the use and/or disclosure of my individually identifiable health information as described in Sections C and D for the purpose listed in Section E. I understand that this authorization is voluntary.
• I have the right to revoke this authorization at any time by sending a signed notice stopping this authorization to the address on page one. The authorization will stop on the date my valid revocation request is received.
    o However, any revocation will not apply to disclosures made by DHCS in reliance upon your authorization. This means that if DHCS made any disclosures of health information because of this authorization, any revocation of the authorization does not apply to the information that was already disclosed.
    o Additionally, any revocation will be ineffective if your authorization was obtained as a condition of obtaining insurance coverage. This means that if your authorization was required to obtain health insurance benefits, the authorization cannot be revoked.
• My treatment, payment, enrollment or eligibility for benefits will not be affected if I do not sign this authorization.
• Health Information disclosed through the authorization may be subject to disclosure and is no longer protected if it is disclosed to anyone other than a covered entity.
    • This means that, if the organization or person that I have authorized to receive my information is ***not*** a health plan or health care provider, the my information may no longer be protected by federal privacy regulations.
• I have the right to receive a copy of this authorization.
• Records and copies obtained relating to outpatient psychotherapy care shall be returned or destroyed at the expiration date of this authorization except those obtained for treatment and diagnosis purposes.

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

Member Signature:	Date: