AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION TO THIRD PARTIES

File Number: _____

By completing this form you are authorizing the California Department of Health Care Services to release your protected health information identified herein to the persons or entities identified herein. 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. Please check the box on page three of this document if you would also like a copy of the requested records sent to you. **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

Your Information		
Last Name:	First Name:	Middle Initial:
Address:	City/State:	Zip Code:
Benefits ID Number:	Date of Birth:	
Telephone Number:	E-mail Address:	

Person/Organization Providing the Information	Person/Organization to Receive the Information
Name: _____	Name: _____
Position or Role: _____	Position or Role: _____
Address: _____	Address: _____
City/State/ZIP: _____	City/State/ZIP: _____
Telephone Number: _____	Telephone Number: _____
Fax Number: _____	Fax Number: _____

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).	

<table>
<tr><th colspan="2">Check Each Type of Protected Information You Want to Access:</th></tr>
<tr><td>☐ Claim Detail Reports, which contain claims paid by Medi-Cal for services received.</td><td>Managed Care Records:
☐ Enrollment Records
☐ Disenrollment Records
☐ Capitation Paid to Health Plan
☐ MERS Fair Hearing Documentation</td></tr>
<tr><td rowspan="2">☐ Treatment/Service Authorization Request Screens. Printouts contain patient names, which providers have requested services, 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.</td><td>Denti-Cal Records:
Call (800) 322-6384</td></tr>
<tr><td>☐ Genetically Handicapped Persons Program (GHPP) and/or California Children’s Services (CCS) Records.</td></tr>
<tr><td>☐ Case Management Records, which contain case manager notes.</td><td>Please contact your care provider or managed care plan if you want access to your medical records.</td></tr>
</table>

I Am Requesting Copies of Records for the Following Dates of Service:

From Date (month/day/year) _____

To Date (month/day/year) _____

Description of the Purpose and Limitations for the Release or Inspection of the Information (Indicate How Information Will Be Used)
The information will not be used for any purpose other than its intended use.

Parent, Guardian, or Personal Representative Information		
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	
☐ 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.	

Please note: A request for records of services provided up to six years ago is a 30-day process. All other requests have an approximate 60-day time frame for 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**

☐ I Request That a Person of My Choosing be Allowed to Inspect My Records. **Note:** Any person or attorney may be named below. Records will not be sent to photocopy services.

Name: _____

Telephone number: _____

Address: _____

Relationship to you: _____

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).

I understand that by signing this authorization:

- I authorize the use and/or disclosure of my individually identifiable health information as described above for the purpose listed. 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 cease on the date my valid revocation request is received.
- An individual may revoke an authorization at any time, provided that the revocation is in writing, except to the extent that: The covered entity has taken action in reliance thereon; or if the authorization was obtained as a condition of obtaining insurance coverage.
- My treatment, payment, enrollment or eligibility for benefits will not be affected if I do not sign this authorization.
- Under California law, the recipient of my medical information is prohibited from re- disclosing the information, except with a written authorization or as specifically required or permitted by law.
- If the organization or person I have authorized to receive the information is not a health plan or health care provider; the released 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: