State of California
Health and Human Services Agency Department of Health Care Services

REQUEST FOR ACCESS TO 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.

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

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:

You must specify dates of service in order to get records.

From Date (month/day/year) _____

To Date (month/day/year) _____

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**

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).

I understand that by signing this authorization:

- I authorize the use and/or disclosure of my individually identifiable health information at the request of the patient (myself). I understand that this authorization is voluntary.
- 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.
- 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: