CDSS
WILL LIGHTBOURNE
DIRECTOR

STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF SOCIAL SERVICES
744 P Street • Sacramento, CA 95814 • www.cdss.ca.gov

EDMUND G. BROWN JR.
GOVERNOR

Unisource
2698 Junipero Avenue, Suite 200
Signal Hill, CA 90755

Dear Sir or Madam:

We are returning this subpoena because disclosure of confidential information such as medical or psychiatric records, or even whether an individual applied for or received benefits, on the basis of a subpoena is unauthorized under State and Federal privacy laws including but not limited to Title 5, USC, Section 552a, 20 CFR, Part 401, 42 USC, Section 1396a, subd. (a)(7), and CFR Sections 164.508, 431.301, 431.305, 431.306, Cal. W&I Code, Section 14100.2, and for both medical and non-medical records Cal. Government Code 6254(k). **Disclosure can be made, however, in response to an authorization signed by the person who is the subject of the records. We have included a copy of the Authorization For Release Of Records Form for your convenience. If you have your own HIPAA-compliant authorization form, you may use that.**

Please be advised that The California Department of Social Services acts as the CA agent on behalf of the Social Security Administration **during the disability evaluation process only**. Once the disability evaluation is complete, the file is **immediately** returned to SSA at another location and CDSS is no longer in possession of the file or the Custodian of Records. Requestors will have to contact SSA directly at one of their Field Offices, not through CDSS.

Once we receive any required authorization and sufficient information to determine the basis upon which the California Department of Social Services may have records relating to the person, the request will be forwarded to the custodian of records for the appropriate division, branch, bureau, or office for his or her direct reply. Please send all further correspondence and inquiries to the contact information listed below.

Sincerely,

Jim Reilley - Senior Legal Analyst
CDSS Legal Division
744 P Street, M/S 8-5-161
Sacramento, CA 95814
(916) 654-1203 / Fax: (916) 654-1171 jim.reilley@dss.ca.gov

RECORDS REQUEST INFORMATION FORM

To be completed by requester and returned to:
California Department of Social Services
Attn: Jim Reilley/Requests For Records
744 P Street, MS 8-5-161
Sacramento, CA 95814

Date: _____

Records regarding: _____

The person whose records you seek:

☐ Is/was a recipient of public social services administered or supervised by the California Department of Social Services (specify which program)

- ☐ CalWORKs
- ☐ Foster Care
- ☐ Adoptions
- ☐ IHSS/PCSP
- ☐ CAPI
- ☐ Assistance Dog Special Allowance
- ☐ California Veterans Cash Benefits
- ☐ Other (specify) _____

☐ Is/was the subject of a disability evaluation for

- ☐ Payments under Title II (SSDI) of the Social Security Act
- ☐ Payments under Title XVI (SSI/SSP) of the Social Security Act
- ☐ Medi-Cal
- ☐ Other (CAPI, ADSA) _____

☐ Is/was an employee of the California Department of Social Services

☐ Is/was a service provider under the IHSS/PCSP programs

☐ Is a resident, applicant, licensee, or employee of a community care facility
FACILITY NAME & ADDRESS:_____

_____

☐ Other (specify) _____

AUTHORIZATION FOR RELEASE
OF
PROTECTED HEALTH INFORMATION

[The person whose records are requested will be called the subject.]

Concerning_____
[Insert Subject's Name]

I, _____ authorize The California Department of Social Services &/or The Social Security Administration to disclose the contents of the file concerning _____ _____, Social Security Number _____, Date of Birth _____. to _____ or their designated agent, with the following exceptions:_____
_____

For the purposes of authenticating of this authorization, I submit the following information with the expectation that it will be compared to the information in the case file:

1. The subject may be contacted at the following address and telephone number:

_____
_____

2. In the application for benefits, the following person(s) was/were identified as knowledgeable witnesses as to the subject's daily activities, function or other aspects of the claimant's physical or other health care condition.

_____
_____

3. In the application for benefits, the following person(s) or facilities were identified as having treated the heath conditions that make the subject unable to work.

_____
_____

4. If I am unable to provide the information requested in each of the previous three questions, I offer the following as alternative information for the purposes of confirming that I am either the subject, or his/her court appointed personal representative.

_____

_____

_____

I am authorizing this disclosure only for the following purpose:_____

_____

It has been explained to me, and I understand, that I have **the right to revoke this authorization** at anytime, by filing a written revocation with the California Department of Social Services, Legal Division, Mail Station 8-5-161, 744 P St., Sacramento, California 95814, Fax number 916-654-1171, Attn: Subpoenas/Requests For Records.

Such written revocation shall be effective at the time received by the Legal Division, but will be inapplicable to all disclosures by the Department prior to the time of it receives the written revocation.

I understand that my decision to sign, or not to sign, this authorization for disclosure of the confidential information concerning the above mentioned claimant, will have **no effect on the determination or outcome of any application for publicly funded benefits**, continued receipt of such benefits, or the disposition of any claim the claimant may have before the Social Security Administration, the California Department of Social Services or the California Department of Health Services concerning any such application or benefits, if any.

I understand that once the California Department of Social Services discloses documents of the type described in this authorization, any such documents disclosed, **will no longer be subject to protection under the Federal Privacy Act, the Privacy Rule of the Health Insurance Portability and Accountability Act, federal Medicaid privacy regulations [42 CFR 431.300 et seq.], or Welfare and Institutions Code sections 10850 or 14100.2, as**

applicable. I understand that I am entitled to receive and to keep a photographic duplicate of this authorization.

This authorization will expire on:

_____.

I certify under penalty of perjury under the laws of the State of California that I am:
[Check the line applicable]

___/ The subject identified above, and that my Social Security Number is _____, and my date of birth is _____.

Signed: _____
Date Signed: _____

___/ The personal representative of the subject of the records described above; that the subject of the records has been determined to be legally incompetent, that I have been duly appointed by a court of competent jurisdiction to act for the subject, and that the court's order empowers me to authorize disclosure of protected health information concerning the subject. My authority to sign this authorization on behalf of the claimant is based on the following:

_____

_____

I am attaching a photographic duplicate of the court's order appointing me as the subject's personal representative.

Signed :_____
Date Signed:_____

[Notice: In addition to the penalties for perjury, to wrongfully secure, use or cause the disclosure of the confidential personal records of a claimant or applicant for, or recipient or beneficiary of, Social Security Insurance benefits, Supplemental Security Income/State Supplementary Payment program benefits, or Public Social Services may be punishable under other state or federal criminal law, and may also be a basis for civil liability.]