REQUEST TO ACCESS PROTECTED HEALTH INFORMATION BY PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE

File Number: ________________

As a parent, guardian, or personal representative you have the right to inspect the Medi-Cal records of the individual you are authorized to represent. You also have the right to request copies of the records. You will be charged for the costs of copying and mailing for some records. You will receive a response to your request within 30 days after we receive your request and payment. If you want copies of your records mailed, you need to send us a photocopy of your California driver license or other listed identification and documentation verifying your authority to represent the stated individual. You will also need to send documentation verifying your address, such as a utility bill displaying your address. **Mail this completed form to:**

Department of Health Care Services
EDS Communications
P. O. Box 526018
Sacramento, CA 95852-6018
(916) 636-1980

INDIVIDUAL WHOSE INFORMATION YOU ARE REQUESTING		
LAST NAME	FIRST NAME	MIDDLE INITIAL
ADDRESS	CITY/STATE	ZIP CODE
BENEFICIARY ID NUMBER	DATE OF BIRTH	DATE OF DEATH (If applicable) DEATH CERTIFICATE MUST BE ATTACHED

DIRECTIONS

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

S/He has 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

S/He is involved in a worker's compensation case in which Medi-Cal has paid for services for the injury s/he received while on the job.

Please call (916) 650-0490 for further information. If none of these circumstances apply, please complete the form.

PARENT, GUARDIAN, OR PERSONAL REPRESENTATIVE INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL
ADDRESS	CITY/STATE	ZIP CODE

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

WHAT LEGAL AUTHORITY DO YOU HAVE TO REQUEST HEALTH INFORMATION OF THE

☐ PARENT

☐ GUARDIAN

☐ MEDICAL POWER OF ATTORNEY

☐ CONSERVATOR

☐ EXECUTOR OF WILL

☐ 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.

WHAT TYPE OF PROTECTED HEALTH INFORMATION DO YOU WANT TO ACCESS?

☐ CLAIM DETAIL REPORTS, which contain claims paid by Medi-Cal for services received. **($25 fee)**

☐ TREATMENT 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.

☐ CASE MANAGEMENT RECORDS, which contain case manager notes.

Managed Care Records:

☐ Enrollment Records
☐ Disenrollment Records
☐ Capitation Paid to Health Plan

Denti-Cal Records:
Call (800) 322-6384

Please contact the managed care plan if you want access to medical records.

I AM REQUESTING COPIES OF RECORDS FOR THE FOLLOWNG 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 6 years ago is a 30-day process. All other requests have a 60-day time frame for additional processing.

METHOD TO RECEIVE YOUR PROTECTED HEALTH INFORMATION

☐ 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 THE 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 IS REQUIRED

☐ 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

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

REPRESENTATIVE SIGNATURE   DATE

NOTE: ANY ATTEMPT TO FALSELY GAIN ACCESS TO PROTECTED HEALTH INFORMATION IS SUBJECT TO LEGAL PENALTIES.