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 be charged for the costs of copying and mailing for some records. Fees are indicated below. 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's license, Department of Motor Vehicles Identification Card, or other valid identification. You will also need to send documentation verifying your address. Checks should be made payable to the California Department of Health Services (CDHS). **Mail this completed form to:**

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

INDIVIDUAL INFORMATION

LAST NAME		FIRST NAME	MIDDLE INITIAL
ADDRESS		CITY/STATE	ZIP CODE
BENEFITS ID NUMBER		DATE OF BIRTH	
DAYTIME TELEPHONE NUMBER (Required) ( )	EVENING TELEPHONE NUMBER ( )	EMAIL ADDRESS	BEST HOURS TO REACH YOU

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

To continue with your request for access to your Medi-Cal records, please go to page 2 and indicate which records you wish to get a copy of. Also, be sure to include the required information for verifying your identity and address, and include payment as indicated.

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 your managed care plan if you want access to your medical records.

I AM REQUESTING COPIE 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 6 years ago is a 30-day process. All other requests have a 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 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.

BENEFICIARY SIGNATURE DATE

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