

***Request For Access To Protected Health Information***

You have the right to request to inspect your Protected Health Information (PHI) in records, which Medi-Cal Dental maintains. You also have the right to request copies of those records. You may be charged for the cost of copying and postage. You will receive a response to your request within 30 days after we receive your request. You will 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:

Medi-Cal Dental Program  
Attn: HIPAA Privacy Contact  
P.O. Box 15539  
Sacramento, CA 95852-1539  
(800) 322-6384

<b>MEMBER INFORMATION</b>			
LAST NAME:		FIRST NAME:	MIDDLE INITIAL:
ADDRESS:		CITY/STATE:	ZIP CODE:
BENEFITS ID NUMBER:		DATE OF BIRTH:	
DAYTIME TELEPHONE NUMBER	EVENING TELEPHONE NUMBER	EMAIL ADDRESS	BEST HOURS TO REACH YOU

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<b>PROTECTED HEALTH INFORMATION YOU WANT TO ACCESS</b>	
WHAT TYPE OF PROTECTED HEALTH INFORMATION DO YOU WANT TO ACCESS?	
<input type="checkbox"/> SUMMARY OF PAYMENTS MADE BY MEDI-CAL DENTAL (CLAIM DETAIL REPORT)  <input type="checkbox"/> TREATMENT AUTHORIZATION REQUESTS	
PLEASE BE SPECIFIC AS YOU MAY BE CHARGED FOR EACH PAGE COPIED.	
FOR WHAT TIME PERIOD DO YOU WANT INFORMATION?	
FROM DATE	TO DATE
<b>METHOD TO ACCESS YOUR PROTECTED HEALTH INFORMATION</b>	
<input type="checkbox"/> PLEASE MAIL ME A COPY OF THE REQUESTED INFORMATION TO THE ADDRESS INDICATED ON PAGE ONE OF THIS FORM.  <input type="checkbox"/> I WISH TO REVIEW THE REQUESTED INFORMATION IN PERSON.  <input type="checkbox"/> I REQUEST THAT A PERSON OF MY CHOOSING BE ALLOWED TO INSPECT MY RECORDS.	
NAME:	
TELEPHONE NUMBER:	
ADDRESS:	
RELATIONSHIP TO YOU:	
<b>IF YOU REQUEST TO REVIEW RECORDS IN PERSON YOU WILL BE CONTACTED TO SCHEDULE AN APPOINTMENT.</b>	

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<b>IDENTIFYING INFORMATION</b>	
<input type="checkbox"/> COPY OF IDENTIFICATION ATTACHED  (PLEASE CHECK TYPE OF IDENTIFICATION) <input type="checkbox"/> CA DRIVER'S LICENSE <input type="checkbox"/> CA DMV IDENTIFICATION CARD <input type="checkbox"/> BIRTH CERTIFICATE <input type="checkbox"/> BENEFITS IDENTIFICATION CARD <input type="checkbox"/> MANAGED CARE CARD <input type="checkbox"/> STATE OR FEDERAL EMPLOYEE ID CARD  IDENTIFICATION NUMBER:	
I UNDERSTAND MEDI-CAL DENTAL MAY NOT AGREE TO REQUESTED RESTRICTION(S), BUT WILL NOTIFY ME OF ITS RESPONSE TO MY REQUEST.  I DECLARE UNDER PENALTY OF PERJURY THAT THE INFORMATION ON THIS FORM IS TRUE AND CORRECT.  MEMBER SIGNATURE: _____ DATE: _____	
(IF NO IDENTIFICATION IS ATTACHED, YOUR SIGNATURE MUST BE NOTARIZED.)  NOTARIZED BY: _____ ON: _____ (DATE)  NOTARY PUBLIC NUMBER:  UNOFFICIAL UNLESS STAMPED BY NOTARY PUBLIC	
<input type="checkbox"/> ADDRESS VERIFICATION ATTACHED  (PLEASE CHECK OR FILL IN FORM OF ADDRESS VERIFICATION) <input type="checkbox"/> UTILITY BILL <input type="checkbox"/> PHONE BILL <input type="checkbox"/> DRIVER'S LICENSE    OTHER	

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

Medi-Cal Dental is committed to protecting the information you provide us. To prevent unauthorized access or disclosure, to maintain data accuracy, and to ensure the appropriate use of the information, Medi-Cal Dental has in place appropriate physical and managerial procedures to safeguard the information we collect.