CONFIDENTIAL

REQUEST TO RESTRICT USE AND DISCLOSURE OF PERSONAL INFORMATION

NOTE: If you are making this request as the personal representative of another person, (e.g., a minor, a conservatee) please use form CDPH 6241 (Restrict Use and Disclosure-Parent, Guardian or Representative) instead of this form.

You have the right to restrict the use and disclosure of your personal information, the California Department of Public Health (CDPH) collects, creates or maintains. You also have the right to request CDPH not to disclose your personal information to a family member, relative, or friend. NOTE: CDPH may refuse to agree to your requested restriction(s) but will notify you of its refusal in its response to your request. This form must be accompanied by a photocopy of your California driver's license, Department of Motor Vehicles Identification Card, or other valid identification. You will also need to send another type of documentation verifying your address (see below). **Mail, fax or email this completed form to**:

Privacy Officer
California Department of Public Health
1415 L Street, Suite 500
Sacramento, CA 95814
(916) 319-9821 (fax)
privacy@cdph.ca.gov (email)

INDIVIDUAL INFORMATION

LAST NAME:	FIRST NAME:	MIDDLE INITIAL:
ADDRESS:	CITY/STATE:	ZIP CODE:
BENEFICIARY ID NUMBER:	DATE OF BIRTH:	

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

DIRECTIONS

WHICH CDPH PROGRAM(S) HAS/HAVE THE PERSONAL INFORMATION ABOUT YOU THAT YOU WANT TO RESTRICT USE AND DISCLOSURE OF?

- ☐ AIDS Drug Assistance Program (ADAP)
- ☐ AIDS Medi-Cal Waiver Program (MCWP)
- ☐ Newborn Screening Program
- ☐ Prenatal Screening Program
- ☐ OTHER (Please list CDPH program(s) which may have your personal information) _____
- ☐ UNKNOWN (If this box is checked, we will call you to assist in determining which CDPH program(s) may have the personal information you are requesting we restrict the use and disclosure.)

CHECK ALL THAT APPLY

☐ **I REQUEST THAT THE CALIFORNIA DEPARTMENT OF PUBLIC HEALTH RESTRICT USE AND DISCLOSURE OF MY PERSONAL INFORMATION IN CARRYING OUT TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS AS FOLLOWS:**

☐ **I REQUEST THAT THE CALIFORNIA DEPARTMENT OF PUBLIC HEALTH RESTRICT THE DISCLOSURE OF MY PERSONAL INFORMATION FROM THE FOLLOWING PERSON (S):**

PLEASE PROVIDE THE NAMES OF ANY FAMILY MEMBERS, RELATIVES…TO WHOM YOU DO NOT WANT CDPH TO DISCLOSE INFORMATION IN THE SPACE ABOVE.

REQUIRED IDENTIFYING INFORMATION

To process your request, you must provide verification of address and identification.

☐ COPY OF ADDRESS VERIFICATION ATTACHED

TYPE (UTILITY BILL, PHONE BILL, DRIVER'S LICENSE, ETC.): _____

☐ COPY OF IDENTIFICATION ATTACHED

TYPE (DRIVER'S LICENSE, DMV IDENTIFICATION CARD, BIRTH CERTIFICATE, BENEFITS IDENTIFICATION CARD, MANAGED CARE CARD, STATE OR FEDERAL EMPLOYEE ID CARD): _____

NUMBER: _____

I UNDERSTAND THE CALIFORNIA DEPARTMENT OF PUBLIC HEALTH MAY NOT AGREE TO THE REQUESTED RESTRICTION(S), BUT WILL NOTIFY ME OF THEIR RESPONSE TO MY REQUEST.

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

REQUESTING INDIVIDUAL'S 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:

DEPARTMENT EMPLOYEE PROCESSING/MAINTAINING THIS REQUEST FOR RESTRICTION ON USE AND DISCLOSURE OF PERSONAL INFORMATION

THIS SECTION TO BE COMPLETED BY DEPARTMENT STAFF

_____
(Name and Title)

_____ _____ _____
(Organization within Department) (Telephone Number) (Mail Stop Number)

PRIVACY STATEMENT (CA CIVIL CODE SECTION 1798.17)

THE INFORMATION COLLECTED ON THIS FORM IS USED TO PROCESS YOUR REQUEST TO RESTRICT USE AND DISCLOSURE OF PERSONAL INFORMATION ABOUT YOU THAT IS MAINTAINED BY THE CALIFORNIA DEPARTMENT OF PUBLIC HEALTH (DEPARTMENT). THE INFORMATION WE COLLECT FROM YOU ON THIS FORM WILL BE KEPT CONFIDENTIAL AND ON FILE AT THE DEPARTMENT, AS REQUIRED BY LAW. ALL INFORMATION REQUESTED ON THE FORM IS MANDATORY PURSUANT TO TITLE 45, CODE OF FEDERAL REGULATIONS, SECTION 164.522. NOT SUPPLYING THE INFORMATION REQUESTED WILL RESULT IN THE DENIAL OF YOUR REQUEST. ANY INFORMATION PROVIDED MAY BE DISCLOSED TO THE CALIFORNIA STATE AUDITOR, THE CALIFORNIA OFFICE OF HEALTH INFORMATION INTEGRITY, THE CALIFORNIA OFFICE OF INFORMATION SECURITY AND PRIVACY PROTECTION, THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES OR TO OTHER STATE AND FEDERAL AGENCIES AS REQUIRED BY LAW.

YOU HAVE THE RIGHT TO REVIEW THE RECORDS WE KEEP ABOUT YOU DURING NORMAL BUSINESS HOURS. THE CALIFORNIA DEPARTMENT OF PUBLIC HEALTH PRIVACY OFFICER WILL, UPON REQUEST, INFORM YOU REGARDING THE LOCATION OF YOUR RECORDS AND THE CATEGORIES OF ANY PERSONS WHO USE THE INFORMATION IN THOSE RECORDS. FOR MORE INFORMATION, CONTACT THE CALIFORNIA DEPARTMENT OF PUBLIC HEALTH, PRIVACY OFFICE, USING THE FOLLOWING CONTACT INFORMATION: CALIFORNIA DEPARTMENT OF PUBLIC HEALTH, OFFICE OF LEGAL SERVICES, PRIVACY OFFICE, 1415 L STREET, SUITE 500, SACRAMENTO, CALIFORNIA 95814 OR BY PHONE 1-877-421-9634.