

REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

File Number: _____

You have the right to request to inspect your protected health information in records, which Denti-Cal 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:

Privacy Contact
c/o Delta Dental of California
P.O. Box 15539
Sacramento, CA 95852-1539
(916) 861-2703

| INDIVIDUAL INFORMATION | | | |
|---------------------------------|---------------------------------|---------------|-------------------------|
| LAST NAME | | FIRST NAME | MIDDLE INITIAL |
| ADDRESS | | CITY/STATE | ZIP CODE |
| BENEFICIARY ID NUMBER | | DATE OF BIRTH | |
| DAYTIME TELEPHONE NUMBER () | EVENING TELEPHONE NUMBER () | EMAIL ADDRESS | BEST HOURS TO REACH YOU |

PROTECTED HEALTH INFORMATION YOU WANT TO ACCESS

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

- SUMMARY OF PAYMENTS MADE BY DENTI-CAL (CLAIM DETAIL REPORT)
- 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

METHOD TO ACCESS YOUR PROTECTED HEALTH INFORMATION

- PLEASE MAIL ME A COPY OF THE REQUESTED INFORMATION TO THE ADDRESS INDICATED ON PAGE ONE OF THIS FORM.
- I WISH TO REVIEW THE REQUESTED INFORMATION IN PERSON.
- I REQUEST THAT A PERSON OF MY CHOOSING BE ALLOWED TO INSPECT MY RECORDS.

NAME _____

TELEPHONE NUMBER () _____

ADDRESS _____

RELATIONSHIP TO YOU _____

IF YOU REQUEST TO REVIEW RECORDS IN PERSON YOU WILL BE CONTACTED TO SCHEDULE AN APPOINTMENT.

IDENTIFYING INFORMATION

COPY OF IDENTIFICATION ATTACHED

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

NUMBER: _____

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

BENEFICIARY 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

ADDRESS VERIFICATION ATTACHED

FORM OF ADDRESS VERIFICATION _____ (UTILITY BILL, PHONE BILL, DRIVER'S LICENSE, ETC.)

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

Denti-Cal 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, Denti-Cal has in place appropriate physical and managerial procedures to safeguard the information we collect.