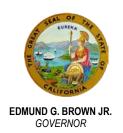


State of California—Health and Human Services Agency Department of Health Care Services



<u>AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH</u> INFORMATION TO THIRD PARTIES (DHCS 6247)

File Number:

By completing this form you are authorizing the California Department of Health Care Services to release your protected health information identified herein to the persons or entities identified herein. You also have the right to request copies of those records. You will receive a response to your request within 30 days after we receive your request. 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. Please check the box on page three of this document if you would also like a copy of the requested records sent to you.

Mail this completed form to address below:

Department of Health Care Services DHCS/MEDI-CAL FI P. O. Box 526018 Sacramento, CA 95852-6018 (916) 636-1980

	Variable farmantian		
Your Information			
Last Name:	First Name:	Middle Initial:	
Address:	City/State:	Zip Code:	
Benefits ID Number:	Date of Birth:		
Telephone Number:	E-mail Address:		

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Person/Organization Providing the Information	Person/Organization to Receive the Information
Name: Position or Role: Address: City/State/Zip: Phone #: () Fax #: ()	Name: Position or Role: Address: City/State/Zip: Phone # : () Fax #: ()
Description of the Specific Info	rmation to be Released/Inspected
	on you Authorize to be Released/Inspected: Alcohol/Drug Information Genetic Testing
Other:	
Information from the categories above will be from (date) to	be authorized for the following period of time: (date).
Check each type of protected infor	mation you want to access:
 □ Claim Detail Reports, which contain claims paid by Medi-Cal for services received. □ Treatment Authorization Request Screens. Printouts contain patient 	- MEROT all Treating Documentation
names, which providers have requested services, which services were requested, the decision about the service(s), including a simple description of the decision, and whethe the provider has billed for these services.	Denti-Cal Records:
☐ Case Management Records, which contain case manager notes.	Please contact your care provider or managed care plan if you want access to your medical records.

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I Am Requesting Copies 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)

Inspection of the Purpos		
The information will not be used	for any purpose other	er than its intended use.
Personal Re	epresentative Inform	ation
Last Name:	First Name:	Middle Initial:
Address:	City/State:	Zip Code:
Telephone Number:	E-mail Address:	
What Legal Authority do You	u Have to Request H	ealth Information
□ Parent of a Minor	☐ Conservator	
	□ Executor of W	Vill
☐ Guardian	☐ Administrator	of Estate
☐ Medical Power of Attorney	□ Other	
Note : You Must Attach Legal Doc Parent, Conservator, Guardian, E Medical Decision-Making Authorit	Executor of a Deceder	

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Please note: A request for records of services provided up to six years ago is a 30-day process. All other requests require approximately 60 days for 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			
Requestor's Identifying Information			
□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 byon(Date).			
Notary Public Number			
UNOFFICIAL UNLESS STAMPED BY NOTARY PUBLIC.			

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This authorization f	for release of th	e above ir	nformation to	the above	named
persons or organiz	ations will expire	e on:	(specific	date).	

I understand that by signing this authorization:

- I authorize the use and/or disclosure of my individually identifiable health information as described above for the purpose listed. I understand that this authorization is voluntary.
- I have the right to revoke this authorization at any time by sending a signed notice stopping this authorization to the address on page one. The authorization will cease on the date my valid revocation request is received.
- An individual may revoke an authorization at any time, provided that the
 revocation is in writing, except to the extent that: The covered entity has taken
 action in reliance thereon; or if the authorization was obtained as a condition of
 obtaining insurance coverage.
- My treatment, payment, enrollment or eligibility for benefits will not be affected if I
 do not sign this authorization.
- Under California law, the recipient of my medical information is prohibited from redisclosing the information, except with a written authorization or as specifically required or permitted by law.
- If the organization or person I have authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations.
- I have the right to receive a copy of this authorization.
- Records and copies obtained relating to outpatient psychotherapy care shall be returned or destroyed at the expiration date of this authorization except those obtained for treatment and diagnosis purposes.

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

Member or Personal Representative Signature:	Relationship if not Member:	Date:

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