REQUEST TO AMEND PERSONAL INFORMATION

You have the right to request amendments to your personal information which the California Department of Developmental Services creates or maintains. We will act upon your request to amend within 30 days of our receipt of your request. If your request is denied, we will let you know the reason(s) for the denial in writing. You will have the right to disagree with our denial of your request for amendment. You may tell us why in a written statement of disagreement which will be added to your record. If we continue to disagree with your requested amendment, we may place a note (rebuttal statement) in your record on why we do not agree with your statement of disagreement. We will send you a copy of our rebuttal statement. You also have the right, under the Information Practices Act of 1977, to request a review of the refusal to amend a record by the head of the agency or a designee. Mail, fax, or email this completed form, with a photocopy of your identification and documentation of your address to:

The Department of Developmental Services
Privacy Officer
1215 O Street, MS 9-30
Sacramento, CA 95814
Fax: (916)654-1716
E-mail: PrivacyOfficer@dds.ca.gov

Confidential Patient Information: *See Welf. & Inst. Code, Section 4514*
HIPAA Privacy Rule CFR Section 164.508

REQUEST TO AMEND PERSONAL INFORMATION

Consumer Whose Information You Want Amended			
Last Name	First Name	Middle Initial	Date of Birth
Address	City/State/Zip		UCI #
Home Phone	Mobile Phone		Email address

Person Requesting Amendment, if Different from Consumer			
Last Name	First Name	Middle Initial	Date of Birth
Address	City/State/Zip		
Home Phone	Mobile Phone		Email address
Relationship to Consumer			

REQUEST TO AMEND PERSONAL INFORMATION

Personal Information You Want Amended
1. Please identify the personal information in your records you want amended.
☐ First Name
☐ Middle Name
☐ Last Name
☐ Address
☐ Email Address
☐ Phone Number
☐ Social Security Number
☐ UCI Number
☐ Medical Information
☐ Other (Please specify):
2. What do you want the record to state now: (attach additional paper if necessary)
3. State the reason you believe the amendment needs to be made:

Confidential Patient Information: *See Welf. & Inst. Code, Section 4514*
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REQUIRED IDENTIFICATION

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

- ☐ Copy of address verification attached. (e.g. utility bill, phone bill, driver's license, etc…)
- ☐ Copy of Identification attached. (e.g. driver's license, DMV Identification Card, Birth Certificate, Benefits Identification Card, Managed Care Card, State or Federal Employee ID Card):

If you are not the consumer, you must also provide legal documentation reflecting your authority to request amendments to the consumer's record.

- ☐ Copy of document providing legal authority to request amendments to the consumer's record attached (e.g. legal documents for appointment of guardianship or conservatorship)

If no identification is attached, your signature must be notarized.

NOTARIZED BY _____ON _____(date)

NOTARY PUBLIC NUMBER _____

(This document must be stamped by the notary public.)

REQUEST TO AMEND PERSONAL INFORMATION

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

Signature of Consumer OR ☐ Personal Representative _____ Date _____

Printed Name _____

DEPARTMENT EMPLOYEE PROCESSING/MAINTAINING THIS AMENDMENT REQUEST
☐ I have verified proof of verification of address and identification. ☐ I have verified authority of the Personal Representative to sign on behalf of the Consumer (if applicable.)
Signature of staff member
Printed Name
Title
Date