DEPARTMENT OF SOCIAL SERVICES

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

SUBPOENA INFORMATION FORM

To be completed by requester and returned to:

SUBPOENAS
California Department of Social Services
744 P Street, MS 4-161
Sacramento, CA 95814

Date: _____

Records regarding: _____

The person whose records you seek:

- ☐ Is/was a recipient of public social services administered or supervised by the California Department of Social Services (specify which program)
  - ☐ CalWORKs
  - ☐ Foster Care
  - ☐ Adoptions
  - ☐ IHSS/PCSP
  - ☐ CAPI
  - ☐ Assistance Dog Special Allowance
  - ☐ California Veterans Cash Benefits
  - ☐ Other (specify) _____
- ☐ Is/was the subject of a disability evaluation for
  - ☐ Payments under Title II (SSDI) of the Social Security Act
  - ☐ Payments under Title XVI (SSI/SSP) of the Social Security Act
  - ☐ Medi-Cal
  - ☐ Other (CAPI, ADSA) _____
- ☐ Is/was an employee of the California Department of Social Services
- ☐ Is/was a service provider under the IHSS/PCSP programs
- ☐ Is an applicant, licensee, or employee of a community care facility
- ☐ Other (specify) _____

Concerning _____

[Insert Claimant's Name]

Authorization for Disclosure of Protected Health Information

I, _____ authorize the Disability and Adult Programs Division of the California Department of Social Services to disclose the contents of the disability determination file concerning _____, Social Security Number _____, Date of Birth _____. to _____ or designated agent, with the following exceptions: _____

_____

_____

_____

[The subject of the records requested above, will be referred to below as the claimant.]

For the purposes of authenticating of this authorization, I submit the following information with the expectation that it will be compared to the information in the case file:

1. The claimant may be contacted at the following address and telephone number:

_____

_____

2. In the application for benefits, the following person(s) was/were identified as knowledgeable witnesses as to the claimant's daily activities, function or other aspects of the claimant's physical or other health care condition.

_____

_____

3. In the application for benefits, the following person(s) or facilities were identified as having treated the heath conditions that make the claimant unable to work.

_____

_____

4. If I am unable to provide the information requested in each of the previous three questions, I offer the following as alternative information for the purposes of confirming that I am either the claimant, or his/her court appointed personal representative.

_____

_____

_____

I am authorizing this disclosure only for the following purpose: _____

_____

_____

_____

It has been explained to me, and I understand, that I have **the right to revoke this authorization** at anytime, by filing a written revocation with the California Department of Social Services, Legal Division, Mail Station 4-161, 744 P St., Sacramento, California 95814, fax number 916-654-1171,

Attn: Elizabeth Sandoval. Such written revocation shall be effective at the time received by the Legal Division, but will be inapplicable to all disclosures by the Department prior to the time of it receives the written revocation.

I understand that my decision to sign, or not to sign, this authorization for disclosure of the confidential information concerning the above mentioned claimant, will have **no effect on the determination or outcome of any application for publicly funded benefits**, continued receipt of such benefits, or the disposition of any claim the claimant may have before the Social Security Administration, the California Department of Social Services or the California Department of Health Services concerning any such application or benefits, if any.

I understand that once the California Department of Social Services discloses documents of the type described in this authorization, any such documents disclosed, **will no longer be subject to protection under the Federal Privacy Act, the Privacy Rule of the Health Insurance Portability and Accountability Act, federal Medicaid privacy regulations [42 CFR 431.300 et seq.], or Welfare and Institutions Code sections 10850 or 14100.2, as applicable.**

I understand that I am entitled to receive and to keep a photographic duplicate of this authorization.

This authorization will expire on: _____.

I certify under penalty of perjury under the laws of the State of California that I am:
[Check the alternative applicable]

___/ The claimant identified above, and that my Social Security Number is _____, and my date of birth is _____.

___/ The personal representative of the subject of the records described above; that the subject of the records has been determined to be legally incompetent, that I have been duly appointed by a court of competent jurisdiction to act for the claimant, and that the court's order empowers me to authorize disclosure of protected health information concerning the claimant. My authority to sign this authorization on behalf of the claimant is based on the following:

_____

_____

I am attaching a photographic duplicate of the court's order appointing me as the subject's personal representative.

/s/_____
Date Signed: _____

[Notice: In addition to the penalties for perjury, to wrongfully secure, use or cause the disclosure of the confidential personal records of a claimant or applicant for, or recipient or beneficiary of, Social Security Insurance benefits, Supplemental Security Income/State Supplementary Payment program benefits, or Public Social Services may be punishable under other state or federal criminal law, and may also be a basis for civil liability.]