Statement of Disagreement
Request to Include Amendment Request and Denial with Future Disclosures

Date of Request: _____

Member Name: _____ Date of Birth: _____

Member CIN: _____ Telephone Number: _____

I understand that CalOptima denied my request to change my Protected Health Information (PHI). My request was dated:_____.

Choose only one (1) box below:

I understand that CalOptima may prepare a rebuttal to my Statement of Disagreement. A "rebuttal" is a statement of why CalOptima thinks my Statement of Disagreement is not accepted. If CalOptima prepares a written rebuttal, I will receive a copy.

☐ I want to file this "Statement of Disagreement."
I disagree with the denial because: _____

_____

_____

_____

☐ I do not want to file a "Statement of Disagreement" but I would like CalOptima to include my change request and the denial with all future disclosures of the information that have to do with my change request.

YOUR RIGHTS:

For more information about your privacy rights, please refer to your copy of the CalOptima Notice of Privacy Practices. A copy can be found on our website: www.caloptima.org, or from CalOptima's Customer Service Department by calling **1-714-246-8500** or toll-free at **1-888-587-8088**, Monday through Friday from 8 a.m. to 5:30 p.m. Members with hearing or speech impairments can call our TDD/TTY line toll-free at **1-800-735-2929**. We have staff who can speak your language.

If you believe your privacy rights have been violated, you may file a complaint with CalOptima or with the secretary of the Department of Health and Human Services. To file a complaint with CalOptima, contact CalOptima Customer Service Department at 1-714-246-8500. CalOptima cannot take away your health care benefits or do anything to hurt you in any way if you choose to file a complaint or use any of the privacy rights in this Notice.

SIGNATURE:

Member Signature: _____

If Authorized Representative (please include legal documentation):

Print Name:_____Relationship to Member: _____