

## CALIFORNIA CANCER REGISTRY PATIENT RECORD REQUEST FORM

Mail Requests to:

Chronic Disease Surveillance and Research Branch  
 California Cancer Registry  
 4800 2<sup>nd</sup> Avenue, Suite 2600  
 Sacramento, CA 95817

<b>INDIVIDUAL WHOSE INFORMATION YOU ARE REQUESTING</b>
*Patient Name:
Patient Alias Name:
*Patient Social Security Number:
*Patient Date of Birth:
*Patient Date of Diagnosis:
*Type of Cancer:
*Patient Date of Death (if applicable): <b>CERTIFIED DEATH CERTIFICATE MUST BE ATTACHED (with raised seal)</b>
Patient Address at Diagnosis:
*Patient County of Diagnosis:
*required fields

<b>REPRESENTATIVE CONTACT INFORMATION</b>		
Last Name:	First Name:	Middle Initial:
Physical Address:	City/State:	Zip Code:
Mailing Address (if different):	City/State:	Zip Code:
Daytime Phone Number:	Email Address:	Please return all certified copies: <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>WHAT LEGAL AUTHORITY DO YOU HAVE TO REQUEST HEALTH INFORMATION:</b>		
<input type="checkbox"/> Self	<input type="checkbox"/> Conservator	
<input type="checkbox"/> Parent	<input type="checkbox"/> Executor of Will	

<input type="checkbox"/> Guardian  <input type="checkbox"/> Medical Power of Attorney	<input type="checkbox"/> Other (Please specify – spouse, son, daughter, etc):
<p><b>NOTE: You must attach all LEGAL documentation to verify that you have legal authority to access the patient’s records (Please refer to the CCR Patient Record Request Check List).</b></p>	

<b>IDENTIFYING INFORMATION REQUIRED</b>	
<input type="checkbox"/> Copy of Identification Attached Type: _____ (Driver’s License, Identification Card, Birth Certificate)	
<input type="checkbox"/> Address Verification Attached TYPE: _____ (Utility Bill, Phone Bill, Driver’s License, Etc.)	
<p><b>IF NO IDENTIFICATION IS ATTACHED, YOUR SIGNATURE MUST BE NOTARIZED.</b>          Notarized by _____ on _____ (Date)          Notary Public Number _____  <b>UNOFFICIAL UNLESS STAMPED BY NOTARY PUBLIC</b></p>	
<p><b>I DECLARE UNDER PENALTY OF PERJURY THAT THE INFORMATION ON THIS FORM IS TRUE AND CORRECT.</b></p>	
Representative Signature:	Date: