CALIFORNIA CANCER REGISTRY PATIENT RECORD REQUEST FORM

Mail Requests to:

Chronic Disease Surveillance and Research Branch
California Cancer Registry
1631 Alhambra Blvd., Suite 200
Sacramento, CA 95816

INDIVIDUAL WHOSE INFORMATION YOU ARE REQUESTING
*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): **CERTIFIED DEATH CERTIFICATE MUST BE ATTACHED (with raised seal)**
Patient Address at Diagnosis:
*Patient County of Diagnosis:
**required fields*

REPRESENTATIVE CONTACT INFORMATION		
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: ☐ Yes ☐ No

WHAT LEGAL AUTHORITY DO YOU HAVE TO REQUEST HEALTH INFORMATION:	
☐ Self	☐ Conservator
☐ Parent	☐ Executor of Will

☐ Guardian ☐ Medical Power of Attorney	☐ Other (Please specify – spouse, son, daughter, etc):
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).	

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