STATE OF CALIFORNIA
CALIFORNIA HEALTH BENEFIT EXCHANGE/COVERED CALIFORNIA (Exchange/CC)

REQUEST FOR AN ACCOUNTING OF DISCLOSURES OF PERSONAL INFROMATION BY A PARENT, GUARDIAN, OR AUTHORIZED REPRESENTATIVE

HBEX 408 (9/15)

Request for an Accounting of Disclosures of Personal Information by a Parent, Guardian, or Authorized Representative

As the Consumer's Authorized Representative, you have the right to request Covered California provide an accounting of any disclosures made to external parties pertaining to the Consumer's Personally Identifiable Information. We will provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another within 12 months. To submit this request, please complete all necessary items and mail the completed form and all relevant documents to:

Privacy Officer
1601 Exposition Blvd.
Sacramento, CA 95815

Consumer Information *(As indicated on your Covered California Account)*		
Last Name:	First Name:	Middle Initial:
Address:	City/State:	Zip Code:
Covered California Case or Incident Number:	Date of Birth:	

Parent, Guardian, or Authorized Representative's Information		
Last Name:	First Name:	Middle Initial:
Address:	City/State:	Zip Code:
Daytime Phone Number *(Required)*	Email Address:	

What legal authority do you have to act on behalf of the Consumer? *(Please attached legal documentation.)*					
Parent	☐	Conservator	☐	Executor of Will	☐
Guardian	☐	Agent of Health Care	☐	Power of Attorney	☐
Other	☐				

Attached Copy of Representative's Identifying Information. *(If no identifying document is attached, your signature must be notarized.)*	
Driver's License ☐	State Identification Card ☐
Federal Issued Identification Card ☐	
Date Notarized:	UNOFFICIAL UNLESS STAMPED BY NOTARY PUBLIC
Notarized By:	
Notary Public Number:	

Describe Your Request
I request Covered California account for the disclosure of Personally Identifiable Information From:_____ (Month/Year) To:_____ (Month/Year)
Is there a specific event Covered California should be looking for?

Authorized Representative's Signature	
I understand Covered California may not be able to comply with my request but will provide me with a response. I declare under penalty of perjury that the information on this form is true and correct.	
Signature:	Date:
The information requested on this form is required by the California Health Benefits Exchange, Privacy Office in order to process your request. The information you provide on this form is required to process your request and will be used by the Privacy Office for that purpose. Failure to provide this information may result in the denial of your request. Legal references authorizing the collection or maintenance of the information provided on this form include Sections 1798.22, 1798.25, 1798.27 and 1798.35 of the California Civil Code and Section 155.260(a) of the Code of Federal Regulations. California Health Benefits Exchange, Privacy Office, 1601 Exposition Blvd, Sacramento, CA 95815 (800) 889-3871.	