PRIVACY REQUEST FORM

Please use this form to submit your Consumer Rights Request to request that CCFMG: provide access to your information; delete your information; not sell your information; and/or provide or withdraw consent to CCFMG's practices regarding personal information as related to someone under the age of 16. You may fill out the form for yourself or someone else (e.g. a dependent or power of attorney).

Your protected health information (PHI) is not included in this request. For questions regarding how CCFMG protects your health information, please visit our **Notice of Privacy Practices** page.

Requestor Information

☐ I am filling out this request out for myself ☐ I am filling out this request out for someone else

ALL FIELDS ARE REQUIRED

Consumer First Name

Consumer Last Name

Date of Birth Month Day Year

Request Type

☐ Access my information
☐ Delete my information
☐ Do not sell my information

To modify your Cookie preferences please use the **Cookie Preferences Page**

☐ Withdraw Consent for a Minor

Response Preference

☐ Email
☐ Paper (US mail)

Email Address ☐ Preferred Contact Method

Phone Number ☐ Preferred Contact Method

Preferred Contact Time ☐ Morning ☐ Afternoon ☐ Evening

Street Address

City

State Zip Code

Penalty of Perjury

☐ I declare under penalty of perjury under the laws of the State of California that the foregoing information is true and correct.

Please return form by email to: privacy@ccfmg.org

or mail to:

Central California Faculty Medical Group
Attention: Compliance Department
2625 E Divisadero Street
Fresno, CA 93721