



# 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@ccfm.org](mailto:privacy@ccfm.org)

or mail to:

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