State of California
Office of Administrative Law

In re:
Department of Corrections and Rehabilitation

Regulatory Action:

Title 15, California Code of Regulations

Adopt sections:
Amend sections: 3999.98, 3999.99, 3999.109, 3999.114, 3999.116, 3999.209
Repeal sections:

NOTICE OF APPROVAL OF CHANGES WITHOUT REGULATORY EFFECT

California Code of Regulations, Title 1, Section 100

OAL Matter Number: 2026-0529-04

OAL Matter Type: Nonsubstantive (N)

In this section 100 action pursuant to California Code of Regulations, title 1, section 100, the California Department of Corrections and Rehabilitation amends a reference citation and form titles for health care services regulations.

OAL approves this change without regulatory effect as meeting the requirements of California Code of Regulations, title 1, section 100.

Date: July 10, 2026

Jenifer Ryan
Senior Attorney

For: Kenneth J. Pogue
Director

Original: Jeffrey Macomber, Secretary
Copy: Adam Burrell

Docusign Envelope ID: 13AFA[illegible]

NONSUBSTANTIVE

STATE OF CALIFORNIA—OFFICE OF ADMINISTRATIVE LAW

NOTICE PUBLICATION/REGULATIONS SUBMISSION

(See instructions on reverse)

For use by Secretary of State only

STD. 400 (REV. 01-2013)

OAL FILE NUMBERS	NOTICE FILE NUMBER	REGULATORY ACTION NUMBER	EMERGENCY NUMBER
	Z-	2026-0529-04	N

For use by Office of Administrative Law (OAL) only

OFFICE OF ADMIN. LAW
2026 MAY 29 PM 4:25

NOTICE | REGULATIONS

ENDORSED - FILED
in the office of the Secretary of State
of the State of California
JUL 10 2026
2:03 PM
NM

AGENCY WITH RULEMAKING AUTHORITY: Department of Corrections and Rehabilitation

AGENCY FILE NUMBER (If any):

A. PUBLICATION OF NOTICE (Complete for publication in Notice Register)

1. SUBJECT OF NOTICE	TITLE(S)	FIRST SECTION AFFECTED	2. REQUESTED PUBLICATION DATE

3. NOTICE TYPE	4. AGENCY CONTACT PERSON	TELEPHONE NUMBER	FAX NUMBER (Optional)
☐ Notice re Proposed Regulatory Action ☐ Other			

OAL USE ONLY	ACTION ON PROPOSED NOTICE	NOTICE REGISTER NUMBER	PUBLICATION DATE
	☐ Approved as Submitted ☐ Approved as Modified ☐ Disapproved/ Withdrawn		

B. SUBMISSION OF REGULATIONS (Complete when submitting regulations)

1a. SUBJECT OF REGULATION(S): Health Care Committees and Compassionate Release

1b. ALL PREVIOUS RELATED OAL REGULATORY ACTION NUMBER(S)

PER AGENCY REQUEST JR

2. SPECIFY CALIFORNIA CODE OF REGULATIONS TITLE(S) AND SECTION(S) **(Including title 26, if toxics related)**

SECTION(S) AFFECTED (List all section number(s) individually. Attach additional sheet if needed.)

ADOPT:

AMEND: 3999.98, 3999.99, 3999.109, 3999.114, 3999.116, 3999.209

REPEAL:

TITLE(S): 15

3. TYPE OF FILING

- ☐ Regular Rulemaking (Gov. Code §11346)
- ☐ Resubmittal of disapproved or withdrawn nonemergency filing (Gov. Code §§11349.3, 11349.4)
- ☐ Emergency (Gov. Code, §11346.1(b))
- ☐ Certificate of Compliance: The agency officer named below certifies that this agency complied with the provisions of Gov. Code §§11346.2-11347.3 either before the emergency regulation was adopted or within the time period required by statute.
- ☐ Resubmittal of disapproved or withdrawn emergency filing (Gov. Code, §11346.1)
- ☐ Emergency Readopt (Gov. Code, §11346.1(h))
- ☐ File & Print
- ☐ Other (Specify) _____
- ☒ Changes Without Regulatory Effect (Cal. Code Regs., title 1, §100)
- ☐ Print Only

4. ALL BEGINNING AND ENDING DATES OF AVAILABILITY OF MODIFIED REGULATIONS AND/OR MATERIAL ADDED TO THE RULEMAKING FILE (Cal. Code Regs. title 1, §44 and Gov. Code §11347.1)

5. EFFECTIVE DATE OF CHANGES (Gov. Code, §§ 11343.4, 11346.1(d); Cal. Code Regs., title 1, §100)

- ☐ Effective January 1, April 1, July 1, or October 1 (Gov. Code §11343.4(a))
- ☐ Effective on filing with Secretary of State
- ☒ §100 Changes Without Regulatory Effect
- ☐ Effective other (Specify) _____

6. CHECK IF THESE REGULATIONS REQUIRE NOTICE TO, OR REVIEW, CONSULTATION, APPROVAL OR CONCURRENCE BY, ANOTHER AGENCY OR ENTITY

- ☐ Department of Finance (Form STD. 399) (SAM §6660)
- ☐ Fair Political Practices Commission
- ☐ State Fire Marshal
- ☐ Other (Specify) _____

7. CONTACT PERSON	TELEPHONE NUMBER	FAX NUMBER (Optional)	E-MAIL ADDRESS (Optional)
Adam Burrell	916-691-0584		Adam.Burrell@cdcr.ca.gov

8. **I certify that the attached copy of the regulation(s) is a true and correct copy of the regulation(s) identified on this form, that the information specified on this form is true and correct, and that I am the head of the agency taking this action, or a designee of the head of the agency, and am authorized to make this certification.**

SIGNATURE OF AGENCY HEAD OR DESIGNEE: DocuSigned by: Jeffrey Macomber 5957F5D0C55F473...

DATE: 5/22/2026

TYPED NAME AND TITLE OF SIGNATORY: Jeffrey Macomber, Secretary

For use by Office of Administrative Law (OAL) only

ENDORSED APPROVED

JUL 10 2026

Office of Administrative Law

TEXT OF PROPOSED REGULATIONS

In the following, ~~strikethrough~~ indicates deleted text and underline indicates added, amended, or moved text.

California Code of Regulations, Title 15, Division 3, Adult Institutions, Programs, and Parole

Chapter 2. Rules and Regulations of Health Care Services

Article 1. Health Care Definitions

Section 3999.98 is amended to update the Credits NOTE and all other text within this section remains unchanged.

Section 3999.98. Definitions.

NOTE: Authority cited: Section 5058, Penal Code. Reference: Section 5054, Penal Code; and *Plata v. Newsom* ~~(N.D. Cal., July 22, 2020, No. 01-CV-01351-JST) 2020 WL 4248685~~ (U.S. Dist. Ct., N.D.Cal., October 3, 2005, No. C01-1351 JST) 2005 WL 2932253.

Section 3999.99 is amended to remove CDCR 7385 (Rev. 01/25), Authorization for Release of Protected Health Information and to delete "CR" and "Compassionate Release" in the title of CDCR 7385 (Rev. 05/25), Authorization for Release of Protected Health Information in the form in section. It is also amended to revert the title of form CDCR 128-C, Medical-Psychiatric Dental Chrono (Rev. 03/25) back to CDC 128-C, Medical-Psychiatric Dental Chrono (Rev. 01/96).

Section 3999.99. Forms.

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CDC~~R~~ 128-C (Rev. 01~~3~~/96~~25~~), Medical-Psychiatric-Dental (Chrono)

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~~CDCR 7385 (Rev. 01/25), Authorization for Release of Protected Health Information~~

CDCR 7385-~~CR~~ (Rev. 05/25), Authorization for Release of Protected Health Information - ~~Compassionate Release~~

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NOTE: Authority cited: Section 5058, Penal Code. Reference: Section 5054, Penal Code.

Subchapter 1. Health Care Governance and Administration

Article 2. Health Care Program Governance

Section 3999.109 is amended to update the Credits NOTE and all other text within this section remains unchanged.

3999.109. Clinical Documentation and Decision Support Committee.

NOTE: Authority cited: Section 5058, Penal Code. Reference: Section 5054, Penal Code; and *Plata v. Newsom* ~~(N.D. Cal., July 22, 2020, No. 01-CV-01351-JST) 2020 WL 4248685~~ (U.S. Dist. Ct., N.D.Cal., October 3, 2005, No. C01-1351 JST) 2005 WL 2932253.

Section 3999.114 is amended to update the Credits NOTE and all other text within this section remains unchanged.

Section 3999.114. Mortality Review and Reporting.

NOTE: Authority cited: Section 5058, Penal Code. Reference: Section 5054, Penal Code; and *Plata v. Newsom* ~~(N.D. Cal., July 22, 2020, No. 01-CV-01351-JST) 2020 WL 4248685~~ (U.S. Dist. Ct., N.D.Cal., October 3, 2005, No. C01-1351 JST) 2005 WL 2932253.

Section 3999.116 is amended to update the Credits NOTE and all other text within this section remains unchanged.

3999.116. Systemwide Pharmacy and Therapeutics Committee.

NOTE: Authority cited: Section 5058, Penal Code. Reference: Section 5054, Penal Code; and *Plata v. Newsom* ~~(N.D. Cal., July 22, 2020, No. 01-CV-01351-JST) 2020 WL 4248685~~ (U.S. Dist. Ct., N.D.Cal., October 3, 2005, No. C01-1351 JST) 2005 WL 2932253.

Subchapter 2. Patient's Entitlements and Responsibilities

Article 1. Provisions of Health Care Services

Section 3999.209 is amended to remove "R" in the title of the form in section (d)(1)(A) and to remove the "CR" and "Compassionate Release" in the title of the form in section (d)(1)(B). It is also amended to remove "R" in the title of the form in section (g)(1)(4) and to remove the "CR" in the title of the form in section (g)(1)(5). All other text within this section remains unchanged.

Section 3999.209. Compassionate Release.

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(d)(1) ***

(A) CDC~~R~~ 128-C, Medical-Psychiatric-Dental (Chrono) and

(B) CDCR 7385-~~CR~~, Authorization for Release of Protected Health Information-~~Compassionate Release~~.

***

(g) ***

(4) CDC~~R~~ 128-C

(5) CDCR 7385-~~CR~~

***

Note: Authority cited: Section 5058, Penal Code. Reference: Section 28(b), California Constitution; and Sections 1170, 1170.18(c), 1172, 1172.2 and 5054, Penal Code.

NAME and NUMBER

CDCR-128-C (Rev. 03/25)

REPEAL

DATE

MEDICAL-PSYCHIATRIC-DENTAL

NAME and NUMBER

CDCR-128-C (Rev. 03/25)

DATE

MEDICAL-PSYCHIATRIC-DENTAL

NAME and NUMBER

CDCR-128-C (Rev. 03/25)

DATE

MEDICAL-PSYCHIATRIC-DENTAL

NAME and NUMBER

ADOPT

CDC-128-C (Rev. 01/96)

DATE

MEDICAL-PSYCHIATRIC-DENTAL

NAME and NUMBER

CDC-128-C (Rev. 01/96)

DATE

MEDICAL-PSYCHIATRIC-DENTAL

NAME and NUMBER

CDC-128-C (Rev. 01/96)

DATE

MEDICAL-PSYCHIATRIC-DENTAL

REPEALED

STATE OF CALIFORNIA
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION
CDCR 7385 (Rev. 01/25)

California Correctional Health Care Services

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

1. PATIENT INFORMATION

Patient Name (Last, First)	Date of Birth	CDCR #

2. PARTIES TO RECEIVE INFORMATION (SELECT ONE)

☐ Patient ☐ Person or Organization Name
Address: _____ City/State/Zip: _____
Email Address/Fax: _____ Phone Number: _____

☐ Federal, state, county, and community-based organizations (including service providers, care coordinators, and case management staff) coordinating pre-release, transition, and post-release services of patient care.

3. PARTY TO RELEASE INFORMATION (SELECT ONE)

☐ CDCR
☐ Organization Name_____

4. PURPOSE

☐ Continuity of Care	☐ Personal Use	☐ Friends or Family	☐ Legal	☐ Other (specify)_____

5. INFORMATION TO BE RELEASED

A. Protected Health Information (select only 1, 2, or 3)

☐ 1. All information related to my care
☐ 2. The following information
- ☐ Mental health information
- ☐ Dental information
- ☐ Medical information
- ☐ Other information (specify) _____

☐ 3. Only HIV test results. I understand that HIV test results are released separate from other health care records. **I agree that by checking this HIV test results box, I authorize the release of specially protected health information. A new authorization will be required for subsequent disclosures.**

B. Specially Protected Health Information (select if applicable)

I understand the types of information below have extra confidentiality protections required by law. I would like the following specially protected health information released if it is in my record:

☐ Regional center developmental disability service records for care provided outside CDCR ("DDS Services")

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

☐ Substance use treatment service records for care provided outside CDCR, including any services provided by a Narcotic Treatment Program ("Part 2 Program Services").

C. Dates of Service (select one)

☐ All dates of service

☐ Only dates of service from (insert dates) _____-_____

6. METHOD OF RELEASE OF INFORMATION (SELECT ALL THAT APPLY)

☐ Written or electronic records (e.g., facsimile, mail, CD)

☐ Verbal correspondence

7. EXPIRATION DATE

This authorization will remain in effect as follows (select one):

☐ This authorization shall remain in effect until revoked by the patient

☐ This authorization expires one year from the date signed below

☐ This authorization expires on the following date: _____.

8. RIGHTS

I understand:

- I may refuse to sign this authorization; refusal will not affect my ability to obtain treatment.
- I may revoke this authorization at any time by providing written notification to California Correctional Health Care Services, Health Information Management Services.
- If I revoke this authorization, my revocation will be effective upon receipt but will have no impact on uses or disclosures made while my authorization was valid.
- I may request a copy of this signed form.
- Information disclosed pursuant to this authorization may be subject to redisclosure by recipient and may no longer be subject to federal and state privacy law protection.
- Even if I do not authorize a release of health information, CDCR may share my confidential information for treatment, payment, and health care operations and other purposes required or permitted by law.

9. SIGNATURES

Signature of Patient/Agent	Date
Print Name of Patient/Agent	Relationship to Patient (if applicable)

If you are the Agent, you must attach documentation of your authority to act on behalf of the patient.

AMENDED

STATE OF CALIFORNIA
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION ~~– COMPASSIONATE RELEASE~~
CDCR 7385~~-CR~~ (Rev. 05/25)

California Correctional Health Care Services

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

1. PATIENT INFORMATION

Patient Name (Last, First)	Date of Birth	CDCR #

2. PARTIES TO RECEIVE INFORMATION (SELECT ONE)

☐ Patient ☐ Person or Organization Name_____
Address: _____ City/State/Zip: _____
Email Address/Fax: _____ Phone Number: _____

☐ Federal, state, county, and community-based organizations (including service providers, care coordinators, and case management staff) coordinating pre-release, transition, and post-release services of patient care.

3. PARTY TO RELEASE INFORMATION (SELECT ONE)

☐ CDCR
☐ Organization Name_____

4. PURPOSE

☐ Continuity of Care	☐ Personal Use	☐ Friends or Family	☐ Legal	☐ Other (specify)_____

5. INFORMATION TO BE RELEASED

A. Protected Health Information (select only 1, 2, or 3)

☐ 1. All information related to my care
☐ 2. The following information
- ☐ Mental health information
- ☐ Dental information
- ☐ Medical information
- ☐ Other information (specify) _____

☐ 3. Only HIV test results. I understand that HIV test results are released separate from other health care records. **I agree that by checking this HIV test results box, I authorize the release of specially protected health information. A new authorization will be required for subsequent disclosures.**

B. Specially Protected Health Information (select if applicable)

I understand the types of information below have extra confidentiality protections required by law. I would like the following specially protected health information released if it is in my record:

☐ Regional center developmental disability service records for care provided outside CDCR ("DDS Services")

AMENDED

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

☐ Substance use treatment service records for care provided outside CDCR, including any services provided by a Narcotic Treatment Program ("Part 2 Program Services").

C. Dates of Service (select one)

☐ All dates of service

☐ Only dates of service from (insert dates) _____-_____

6. METHOD OF RELEASE OF INFORMATION (SELECT ALL THAT APPLY)

☐ Written or electronic records (e.g., facsimile, mail, CD)

☐ Verbal or written correspondence (Note: This option is not available to patients who have paroled or discharged from CDCR.)

7. EXPIRATION DATE

This authorization will remain in effect as follows (select one):

☐ This authorization shall remain in effect until revoked by the patient

☐ This authorization expires one year from the date signed below

☐ This authorization expires on the following date: _____.

8. RIGHTS

I understand:

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- I may revoke this authorization at any time by providing written notification to California Correctional Health Care Services, Health Information Management Services.
- If I revoke this authorization, my revocation will be effective upon receipt but will have no impact on uses or disclosures made while my authorization was valid.
- I may request a copy of this signed form.
- Information disclosed pursuant to this authorization may be subject to redisclosure by recipient and may no longer be subject to federal and state privacy law protection.
- Even if I do not authorize a release of health information, CDCR may share my confidential information for treatment, payment, and health care operations and other purposes required or permitted by law.

9. SIGNATURES

Signature of Patient/Agent	Date
Print Name of Patient/Agent	Relationship to Patient (If applicable)

If you are the Agent, you must attach documentation of your authority to act on behalf of the patient.

DISTRIBUTION: Original: Health Records; Copies: Patient
EHRS LOCATION: Administrative – Authorization for Release of Health Care Record; Authorization for Release of PHI