Statement of Disagreement for Denial of Access to Health Information

Name:	Date:
Mailing Address:	Date of Birth:
City/State/Zip:	Medicaid ID# or Soc. Sec.#:

I disagree with the decision to deny my request to access my protected health information because:

Signature of Individual or Personal Representative Authorized by Law: Date

Signature of Witness (If signed with an "X' or mark): Date

Return this form to:

LDH USE ONLY

Date received:

❒ **Rebuttal** ❒ **No Rebuttal**

Comments:

Signature & Title of Agency Representative Date

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