Request for Review by the Program Privacy Officer for Denial of Access to Health Information

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

I Disagree with the decision to deny my request to access my protected health information because:
(You may use additional pages if needed)

____ ____________________
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: ______________________________________

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LDH USE ONLY

Date received: ______________________________ **Assigned to:** ________________________

Comments: (You may use additional pages if needed)

____ ____________________
Signature & Title of Agency Representative Date

Issued 4/14/03
Revised 09/17/2013

Sample Form: The Program / Office Mailing Address must be added.