



Acceptance of Restriction Request

| | |
|--------------------------------|-----------------------------|
| Insert Client Name and Address | Medicaid ID# or Soc. Sec. # |
| | Date Filed |
| | Date Processed |

Dear (Client name):

Thank you for submitting your request for restriction to your health information.

- Your request has been accepted in full. The appropriate restriction to your protected health information and/or record has been made to your _____ record.
(ie. eligibility, medical)
- Your request has been accepted in part. You will receive a separate letter about the area of your request that was denied.
- Please contact _____ to schedule an appointment to discuss the health information you requested to restrict.
- Other: _____

Sincerely,

Name
Job Title

c: Case File