LOUISIANA DEPARTMENT OF HEALTH

Response to Statement of Disagreement to Restriction Request

Insert Client Name and Address	Medicaid ID# or Soc. Sec. #
	Date Filed
	Date Completed

Dear(Client name):

We received your "Statement of Disagreement" in response to our letter notifying you that we denied your "Restriction of Use and Disclosure Request Form." As part of the restriction request procedure, your initial request, your statement of disagreement, and the supporting documents were forwarded for further review to a third party within our agency who was not involved in the original decision to deny your request.

After considering your initial request, our denial of the request, and your statement of disagreement, along with your medical record, the third party determined that:

- ❒ The initial "Restriction of Use and Disclosure Request Form" that you submitted will be honored and the requested restriction to your health information will be made.
- ❒ Please contact _____ to schedule an appointment to review the health information you requested to restrict.
- ❒ Your request continues to be denied. Your request for restriction, our denial of the request, your statement of disagreement, and our rebuttal statement will be added to your medical record.

If you would like to file a complaint you may contact the _____*(Program)* Privacy Office at:
(Give information here: address, telephone number, and Program's privacy e-mail address.)

_____ _____
Agency Representative and Title Date

c: Case File
Program Privacy Office *(i.e. Medicaid, OCDD, OPH, OBH, OAAS)*

Sample Form: The Program / Office mailing address must be added.