EVMS MEDICAL GROUP

REQUEST FOR REVIEW OF DENIAL OF ACCESS TO PROTECTED HEALTH INFORMATION

REQUEST SECTION

I, _____ understand that I have the right to request
Patient Name
that the decision to deny access to, or copies of, my Protected Health Information be reviewed by another physician or clinical psychologist whose licensure, training and experience relative to my condition are at least equivalent to that of the physician or clinical psychologist upon whose opinion the denial was based.

I designate, at my own expense, the following individual to provide this review.

_____
Name

_____
Address

_____
Telephone Number

or

I request that _____ designates, at its own expense, a
Department/Division
physician or clinical psychologist to provide this review.

Patient's Date of Birth or SSN: _____

_____ _____
Signature *Date*

Personal Representative of
Patient:_____
Name *Signature* *Date*

Authority or relationship to Patient:_____

……

(Office use only)

REVIEW SECTION This section is to be completed by the reviewer:

Date Request Received:	**Request Reviewed by:**	**Date patient notified:**
Request Received by:	**Date of Request Review:**	**Person notifying patient:**

The above request is hereby:
Granted ___;
Appointment time/date:_____ with_____
Name of staff member

Denial upheld ___;
Reason for the denial: _____