



REQUEST FOR ACCESS TO HEALTH INFORMATION

FOR OFFICE USE ONLY

REQUEST RECEIVED/REVIEWED			
Access request received on:		Received by:	
Access request reviewed by:			
Request has been:	<input type="checkbox"/> Accepted in full	<input type="checkbox"/> Accepted in part	<input type="checkbox"/> Denied
Letter indicating decision mailed to patient on:			

Signature of Reviewer

Date

IF PATIENT WAS GIVEN ACCESS IN FULL, COMPLETE INFORMATION BELOW:			
The record was:		Staff member who assisted the patient in viewing his/her information was:	
<input type="checkbox"/> Viewed by the patient on:			
<input type="checkbox"/> Sent electronically on:			
<input type="checkbox"/> Copied on:			
<input type="checkbox"/> Picked up by patient on:	<input type="checkbox"/> Mailed via US mail on:	<input type="checkbox"/> Sent to patient via ____ on:	<input type="checkbox"/> Faxed to patient on:

IF PATIENT WAS GIVEN ACCESS IN PART, COMPLETE INFORMATION BELOW:
Indicate which part(s) have been denied and the reason(s) why below:

REVIEW	
Has the patient asked for a review of the decision? <input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, letter asking for review received on:
Decision reviewed on:	Decision reviewed by:
Reviewing official's decision:	<input type="checkbox"/> Affirm decision <input type="checkbox"/> Overturn decision (complete the disclosure information above)
Patient notified of reviewing official's decision in letter/fax sent on:	

IF DENIED, COMPLETE THE INFORMATION BELOW:
If denied, indicate why the request has been denied (be specific):

COMMENTS OF HEALTHCARE PRACTITIONER OR REVIEWER: