[Insert Letterhead]

Right to Access - Final Determination

Dear [Insert Patient name],

A licensed health care professional has reviewed [Insert Covered Entity name] decision to deny you access to your protected health information. The reviewer determined that the decision should be [Insert “upheld” or “overturned”] because [Insert specified reason].

* Choose one of the options below:
* **I**f the decision is overturned: You may contact [Insert contact name and number] to arrange a time for inspection.
* Your health information is enclosed
* If the decision is upheld: This is a final decision and is not subject to further review.

You have the right to file a Complaint with us or with the Department of Health and Human Services Office for Civil Rights, [Insert Address]. The complaint should be directed to the Regional Manager. He/She may be reached at [Insert phone number] or by fax at [Insert fax number]. To file a complaint with us, contact the Privacy Officer.

If you have any questions, you may call [Insert contact name and number]. If you would like to review our Notice of Privacy Practices, please let us know and one will be sent to you.

Sincerely,

[Insert Covered Entity contact name and information]