[Insert Letterhead]

**Right to Access - Request for Review of Denial**

Please complete this form and give it to the Privacy Officer.

|  |  |
| --- | --- |
| Date: |  |
|  |  |
| Date of Original Request for Access: |  |
|  |  |
| Requestor’s Name and Address: |  |
|  |  |
| Telephone Number: |  |

|  |  |
| --- | --- |
| Give your reason for requesting review: |  |
|  |  |
|  |  |

**Patient Rights:** You have the right to have our denial of access to protected health information reviewed. You have the right to file a complaint 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]. You may also speak with [Insert Covered Entity Contact name and number].