

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 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 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:

Table with 3 columns: 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 _____
Denial upheld ___;
Reason for the denial: _____