



DEPARTMENT OF MENTAL HEALTH

hope. recovery. wellbeing.

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Senior Deputy Director

[Please ensure use of current letterhead and delete this line before printing.]

Date: Click or tap to enter a date.

Client ID #:

RE: Response Letter

Dear _____,

Thank you for submitting your **Request for Access/Inspection to Health Information**. Your written request was received and stamped on Enter a date. It was forwarded to the responsible practitioner for review.

- Your request has been accepted, and:
 - The following appointment time has been scheduled for your records review:
 - Date: Enter a date.
 - Time: Click or tap here to enter text.
 - Location: Click or tap here to enter text.

If you have any questions or need to reschedule, please contact the treatment team or call us at _____.

- We will grant your request to access, but only in part (see below regarding the reason for partial denial). We will provide access to the following health information:
Click or tap here to enter text.
- Your request to access your protected health information is denied because:
 - You are not authorized access to the health information.
 - We are not permitted to release health information regarding information compiled in anticipation of or use in a civil, criminal, or administrative action or proceeding. **This denial is not subject to the right to review.**
 - You did not provide all the information we need to complete your request. Please complete the highlighted items identified and return it to us.

- You were unable to provide satisfactory personal identification to access your information.
- You were unable to provide satisfactory personal identification as proof of status as a patient's representative (parent, guardian or conservator).
- Other:

If we denied your request to access/inspect your protected health information, you have the right to require LACDMH to permit inspection by a licensed mental health professional designated by you with your written authorization. If you want to exercise this right, please contact your treatment team.

Request for Review of Denial of Access/Inspection (If Applicable)

If we denied your request to access/inspect your protected health information, in whole or in part, you may submit a [Request for Review of Denial of Access/Inspection](#), included with this letter. After completing the form, return it to your treatment team or mail it to:

Office of Patients' Rights
Los Angeles County Department of Mental Health
500 S. Vermont Ave.
Los Angeles, CA 90020
Phone: (213) 738-2524, (800) 700-9996

You also have the option to submit a complaint to either the County's Privacy Official or the federal government.

To file a complaint with Los Angeles County, contact:

HIPAA Compliance Officer
County of Los Angeles, Chief Executive Office
Risk Management Branch - Office of Privacy
320 W. Temple Street 7th Floor
Los Angeles, CA 90012
Phone: (213) 974-2164
Email: PRIVACY@ceo.lacounty.gov

To file a complaint with the federal government, contact:

Region IX, Office for Civil Rights
U.S. Department of Health and Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
Phone: (800) 368-1019
Fax: (202) 619-3818
TDD: (800) 537-7697

Thank you for providing us with this opportunity to serve you and improve the accuracy and completeness of your health information. We look forward to continuing to serve your healthcare needs.

Sincerely,

Enter Program/Unit Manager Name
Department of Mental Health
Los Angeles County