Clear entire form

CLIENT'S REQUEST FOR REVIEW OF DENIAL OF ACCESS

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH ("LACDMH")

CLIENT:

Name of Client	Date of Birth	Client ID #

Street Address	City, State, Zip

I am requesting a review of denial of access to my protected health information.

LACDMH will designate a licensed health care professional, who was not involved in the decision to deny access, to review the determination. We will notify you in writing of the determination of the reviewing health care professional. LACDMH must adhere to the determination of the reviewing professional.

Signature of Client / Personal Representative **Date**

If signed by other than the client, state relationship and authority to do so: _____

Facility **Practitioner** **Date**

For more information about your health privacy rights, ask the Treatment Team for a copy of our **Notice of Privacy Practices**. You may also obtain a copy by visiting our website at http://dmh.lacounty.gov/wps/portal/dmh or by sending a written request to:

Office of Patient's Rights
Los Angeles County Department of Mental Health
510 S. Vermont Ave., 21st Floor
Los Angeles CA 90020

Phone: (800) 700-9996 Fax: (213) 330-0285

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.