REQUEST FOR RECONSIDERATION OF DENIAL OF ACCESS TO HEALTH INFORMATION

I understand that my request was denied for access to Health Information regarding:	
Name of Patient	Dated
I request that this denial be reconsidered by another health care professional who did not participate in the original decision to deny my request.	
Signature	Date
Print name	Telephone #
If not signed by the patient, please indicate relationship	
Name of Patient:	
☐ Parent or guardian of minor patient	
☐ Guardian or conservator of an incompetent patient	
☐ Beneficiary or personal representative of deceased patient	
☐ Other (specify)	