

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

MIS #

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://www.dmh.co.la.ca.us/> or by sending a written request to:

**Patient’s Rights Office
Los Angeles County Department of Mental Health
550 S. Vermont Ave., 5th Floor
Los Angeles CA 90020**

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.