CVH-184d
Rev. 4/03

CONNECTICUT VALLEY HOSPITAL
P.O. Box 351
MIDDLETOWN, CONNECTICUT 06457

DENIAL OF ACCESS TO AND REQUEST FOR ALTERNATE REVIEW OF YOUR MEDICAL RECORD

Date:

Dear _____,

We are very sorry to notify you that your request for access to your medical record is being denied. This action is taken in accordance with the provisions of Section 4-194 of the Connecticut General Statutes.

Reason for denial:

_____

_____

_____

_____ _____
Physician Signature Date

Return form to HIM for further processing

REQUEST FOR ALTERNATE TO REVIEW MEDICAL RECORD

You may authorize a licensed physician of your choice to review your medical record or to obtain copies on your behalf. If you choose to exercise this option, please complete the authorization below and give this form to your Head Nurse, Patient Advocate, or sent it directly to Health Information Management.

PATIENT SECTION:

I, _____ am notifying you that in accordance with Section 4-194(b) of the Connecticut General Statutes, I wish to name an alternate to review the medical record to which I have been denied access. Please make my medical record available to:

Physician's Name _____

Address _____

_____

Phone Number_____

Patient Signature _____ Date_____

Send completed form to: Health Information Management (HIM)

HIM Processing: Date sent to Alternate Physician: _____

ORIGINAL – Medical Record (Correspondence Section)
COPIES – Alternate Physician, Attending Psychiatrist and Patient