CVH -524
New 4/03

CONNECTICUT VALLEY HOSPITAL
Physician Review of Patient's Request for Protected Health Information

Patient Name ____ MPI# ____________________________

Requestor's Name ______________________________________ Relationship to Patient

Purpose of Disclosure
(See Also: Authorization For Use And Disclosure Of Protected Health Information form (CVH-184) completed by requester)

Requested Information: [ ] Entire Record [ ] Abstract of Record to include:

[ ] Admission/Annual Assessments

[ ] Psychiatric and/or Psychological Exam

[ ] Discharge Summary

[ ] Other

Additional Comments/Concerns:

THIS SECTION TO BE COMPLETED BY:
THE ATTENDING PHYSICIAN or CHIEF OF PROFESSIONAL SERVICES

Date:

Dr. ____________________ , the above named patient, or other interested party as stated above, is requesting a copy of documentation in the medical record of the above listed patient. Please record your decision below and return this form to the Medical Record Department.

[ ] **NO** Request for copies of the medical record document(s) listed above is **DENIED**. The Medical Record Department will notify the patient/requestor of your decision and will advise them of their right to have a physician of their choice review their request.

REASON for denial of request:

[ ] **YES** I authorize that this patient/requestor may receive the above listed document(s). The Medical Record Department will process request.

[ ] **APPOINTMENT necessary** with the patient/requestor to further evaluate the request. The Medical Record Department will arrange an appointment for you with the patient/requestor.

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Physician Signature

Date