CVH-666
New 4/03

CONNECTICUT VALLEY HOSPITAL
REQUEST FOR APPEAL OF DENIAL

Name ______________________________ Unit ______________

You have the right to appeal a hospital decision to deny your request related to your Protected Health Information. Please check the denial you are requesting to appeal. If you need assistance completing this form contact your Head Nurse, Patient Advocate or the Director of Health Information Management.

For review by the Director of Health Information Management:

[ ] Access to your medical record
[ ] Copy of your medical record

Date of original request or denial ______________

Date of review by Alternate Physician ______________ Date of review by Superior Court ______________

Summary of request/denial ______________________________

____

____

Patient Signature______________________________ Date______________

Please attach a copy of denial notices from your Attending Physician, Alternate Physician and decision of the Superior Court and send completed form to: Director Health Information Management – Merritt Hall

For review by the Director of Health Information Management:

[ ] Amend (correct) your medical record

Date of original request or denial ______________

Summary of request/denial ______________________________

____

____

Patient Signature______________________________ Date______________

Please attach copy of denial notice and send completed form to: Director Health Information Management – Merritt Hall

For review by the CVH Privacy Officer:

[ ] Receive confidential communication in an alternate manner
[ ] Restrict the use and disclosure of your Protected Health Information

Date of original request or denial ______________

Summary of request/denial ______________________________

____

Patient Signature______________________________ Date______________

Please attach copy of denial notice and send completed form to: CVH Privacy Officer – Page Hall

Appeal Decision:

Your request for appeal of denial has been reviewed. The determination based on this review is:

[ ] Your initial request as described above is granted.

[ ] Your initial request as described above is denied.

Signature/Title______________________________ Date______________

You have the right to further appeal through the Department of Mental Health and Addiction Services (DMHAS), Office of Healthcare Information. If you choose to exercise this option, please sign below and give this form to your Head Nurse, Patient Advocate or send it directly to Health Information Management. You will be informed of a decision within 30 days of receipt of your request.

[ ] I wish to appeal this denial to the DMHAS Office of Healthcare Information.

Patient Signature______________________________ Date______________