



University of Connecticut
Health Center

Farmington, CT 06030

HCH - 1351 REV - 04/03 EFF - 04/14/03

Patient ID

MRN:

NAME

**REQUEST TO ACCESS /NOTIFICATION OF ACCESS OR DENIAL
ACCESS REQUEST:**

Patient Name: _____ MRN #: _____
Request for access to which record: _____
Signature of Patient (or legal representative) _____ Date _____

NOTIFICATIONS:

NOTIFICATION OF ACCESS TO RECORD:

Patient request to access has been approved. Date of access granted: _____

NOTIFICATION OF DENIAL OF ACCESS TO RECORD:

DENIAL (may not be contested by patient): Date of Denial: _____

- Psychotherapy notes Court/Administrative Exception to Access by Law Inmate CLIA
- Research in Progress (may be available on conclusion) Promise of Confidentiality

Comments: _____

DENIAL (may be contested by patient*) Risk of Harm Date of Denial: _____

Explanation/basis for denial: _____

*For any reason given where you may contest the denial, you have the right to request that UCHC have the denial reviewed by a designated licensed health care professional here at UCHC who did not participate in the original denial. Based upon this reviewing official's determination we must either provide you access to the requested information or continue this denial.

I now request this review: _____
Signature of person requesting review of denial

Filing a complaint:

Director of Patient Relations
University of Connecticut Health Center
Farmington, CT 06030
Mail Code: 1112
Phone 860-679-3176

Regional Manager, Office for Civil Rights
DHHS Government Center
J.F. Kennedy Federal Building - Room 1875
Boston, Massachusetts 02203
Voice phone (617) 565-1340
FAX (617) 565-3809 TDD (617) 565-1343

Your complaint must be in writing, filed within one hundred eighty (180) days of when you knew or should have known of the denial, and name UCHC as the party you are complaining against.