EXTENSION NOTIFICATION

[Date]

[Patient Name]
[Street Address 1]
[Street Address 2]
[City, State Zip Code]

Re: Request For A Copy Of Health Information

Dear [Patient Name]:

This letter responds to your request for a copy of your health information, which we received from you on ______________________.

We have been working hard to determine whether we can grant your request. We are usually able to process requests for copies within thirty (30) days. However, for the following reason(s), we need an additional 30 days to respond to your request for copies of these records:

☐ We are still working to access the information you requested.

☐ We are still working to prepare the information you requested.

☐ We are still working to determine whether all or part of your request may be granted.

We expect to have a final answer for you no later than ______________________. If additional time is required, we will notify you again.

Please contact the ___________________ Department of SUNY Downstate Medical Center University Hospital of Brooklyn at (718)270-______ if you have questions or concerns about this delay.

Sincerely,

_________________ Department

FEE ESTIMATE FOR SUMMARIES AND/OR EXPLANATIONS

[Date]

[Patient Name]
[Street Address 1]
[Street Address 2]
[City, State Zip Code]

Re: Request For Access to Health Information

Dear [Patient Name]:

This letter responds to your request to access your health information, which we received from you on ______________________.

We have determined that the following fees will apply if we process your request:

- ☐ A fee of $ ____________ will be charged to prepare a summary of the information for you. We estimate that the preparation will take ___ hour(s).

- ☐ A fee of $ ____________ will be charged to prepare an explanation of the information for you. We estimate that the preparation will take ___ hour(s).

We want you to know that you have the following options. Please check the appropriate box and return within thirty (30) days to SUNY Downstate Medical Center University Hospital of Brooklyn, ____________Department- Box #_______, 450 Clarkson Ave., Brooklyn, NY 11203.

- ☐ Proceed with my request. I have enclosed the fee provided in this letter.
- ☐ Withdraw my request. I will pay no fee.
- ☐ Modify my request to reduce the applicable fee. Specify modification of request:

____

____

If we do not hear from you within thirty (30) days, we will assume that you have decided to withdraw your request.

____________________ Department

NOTICE OF DENIAL LETTER

[Date]

[Patient Name]
[Street Address 1]
[Street Address 2]
[City, State Zip Code]

Re: Denial of Request To Access Health Information

Dear [Patient Name]:

This letter responds to your request to access your health information, which we received from you on ________________________. For the reasons stated below, we are denying your request for access to all or part of this information:

- ❑ The request was not in writing.
- ❑ The information requested is not available in records we use to make decisions about your treatment or benefits. However, this information may be available in records maintained by ___________________________ at the following telephone number __________________.
- ❑ We have obligations to other parties to keep the information you requested confidential. Our staff has determined that granting your request would violate our confidentiality obligations.
- ❑ An authorized officer from a correctional institution has certified that granting your request to copy your information would jeopardize the health, safety, security, custody or rehabilitation of you or another person.
- ❑ We believe that granting your request is reasonably likely to endanger a person's life or physical safety.
- ❑ The information you have requested refers to another person (who is not a health care provider) and we believe that granting your request is reasonably likely to cause substantial harm to that other person.
- ❑ You are the patient's personal representative, and we believe that granting your request is reasonably likely to cause substantial harm to the patient or a third person.
- ❑ The form/format in which you requested the information is not readily producible. Please contact us to identify an alternatively acceptable form/ format for the information.

This denial applies to ❑ ALL or ❑ PART of the information you requested. We will provide you with a summary of any information we cannot permit you to access. If we are denying only part of your request, you will be given complete access to the remaining information after we have excluded the parts which we cannot permit you to access.

You have the right to have this decision reviewed by licensed health care professionals not directly involved in our initial decision to deny your request. If you want to exercise this right, please check the box at the bottom of this form, sign and return to:

SUNY Downstate Medical Center University Hospital of Brooklyn
Department of Health Information Management- Box #119
450 Clarkson Ave.
Brooklyn, NY 11203

We will comply with the health care professionals' decision. If the health care professionals agree with our decision, you will have the opportunity to seek further review by a special committee appointed by the State of New York.

If you believe that we have improperly handled your request to access your protected health information, you may file a complaint with us or with the Secretary of the United States Department of Health and Human Services. To file a complaint with us, please contact the Department of Patient Relations at (718) 270-1111. *No one will retaliate or take action against you for filing a complaint.*

❑ I would like to have your denial reviewed by licensed healthcare professionals, as stated above.

_______________________________________ ___________________________

Signature of Patient or Personal Representative Date

NOTICE OF DENIAL REVIEW LETTER

[Date]

[Patient Name]
[Street Address 1]
[Street Address 2]
[City, State Zip Code]

Re: Denial of Request To Access Health Information- Results of Review

Dear [Patient Name]:

This letter notifies you of the results of the review provided by licensed health care professionals who were not directly involved in our initial decision to deny your request to access your protected health information. The health care professionals who reviewed your request have reached the following conclusion.

- ☐ Your request was properly denied for the reason provided in the hospital's initial notice.

- ☐ Your request was improperly denied for the reason provided in the hospital's initial notice, but is properly denied for another reason, which is ________________________.

- ☐ Your request was properly denied with respect to part of the information. The request was not properly denied for another part of the information. Please contact the Correspondence Unit at (718) 270-1845 to set up an appointment to inspect the information which you are entitled to access. If you have requested copies, we will provide them in the manner requested on your initial request form after we have removed the information that we cannot permit you to access.

- ☐ Your request was improperly denied. Please contact the Correspondence Unit at (718) 270-1845 to set up an appointment to inspect the information. If you have requested copies, we will provide them in the manner requested on your initial request form.

You have the right to have this decision reviewed by a committee appointed by the State of New York. If you want to exercise this right, please complete the form included with this letter and send it to the address provided on the form.

If you believe that we have improperly handled your request to access your protected health information, you may file a complaint with us or with the Secretary of the United States Department of Health and Human Services. To file a complaint with us, please contact the Department of Patient Relations at (718) 270-1111. *No one will retaliate or take action against you for filing a complaint.*