SUNY DOWNSTATE Medical Center

REQUEST FOR ACCESS- 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.

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