

**REQUEST TO REVIEW THE DENIAL OF A
DOCUMENTATION REQUEST**

PATIENT'S LAST NAME	FIRST	M.I.
CASE NO.		
FACILITY	UNIT	

INSTRUCTIONS: GIVE A COPY OF THE FORM TO THE PATIENT! Prepare one (1) copy for the Patient's Case Record.

REQUEST FOR REVIEW

ORIGINAL REQUEST TYPE

- ☐ REQUEST TO AMEND RECORD
- ☐ REQUEST TO INSPECT/COPY RECORD
- ☐ REQUEST TO RESTRICT USE OF CONFIDENTIAL INFORMATION

REASON FOR REVIEW OF DENIAL

I, the undersigned, hereby request that the denial of my request (described above) be reviewed. I understand that the facility may deny my request with cause.

(Signature of Patient)

(Signature of Parent/Guardian, when required)

(Print Name of Patient)

(Print Name of Parent/Guardian)

(Date)

(Date)

Facility Action:

___ Request approved.

___ Request Denied. Reason for Denial

___ The material to be amended was not created by the program.

___ The material is a psychotherapy note or is information compiled in anticipation of or for use in a civil, criminal, or administrative action or proceeding

___ The program determines that the record is accurate and complete.

___ Other reason. Describe _____

Director/Assistant Director

Date