Request to View Record / Notification of Approval or Denial to View

Patient Name: ___________________________ MRN#: ___________________________
Request to view which record: ____________________________________________________
______________________________________________________________________________
______________________________________________________________________________
Signature of Patient (or legal representative [proof required]) Date Time □ am □ pm

NOTIFICATION OF APPROVAL OR DENIAL:

NOTIFICATION OF APPROVAL: / / : am
Patient request to view has been approved. Date approved Time approved □ am □ pm
Signature of Approving Provider: _____________________________________________

NOTIFICATION OF DENIAL TO VIEW RECORD: / / : am
Date of Denial Time of Denial □ am □ pm
Signature of Denying Provider: _____________________________________________

CHOOSE ONE TYPE OF DENIAL BELOW:

1. DENIAL (these may not be contested by patient): □ Psychotherapy Notes □ Inmate
   □ Court/Administrative □ Exception to Access by Law □ CLIA □ Promise of Confidentiality
   □ Research in Progress (may not be available on conclusion)
2. DENIAL (these may be contested by patient *): □ Risk of Harm

Explanation for denial: _______________________________________________________

*For any reason given where you may contest the denial, you have the right to request that UConn
Health have the denial reviewed by a designated licensed health care professional here at UConn
Health 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: / / : am
Signature of person requesting review of denial Date Time □ am □ pm

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

Director of Patient Relations
Regional Manager, Office for Civil Rights
UConn Health
DHHS Government Center
263 Farmington Ave.
J.F. Kennedy Federal Building – Room 1875
Farmington, CT 06030
Boston, Massachusetts 02203
Mail Code: 2826
Voice phone: (800) 368-1019
Phone: (860) 679-3176
Fax: (617) 565-3809    TDD: (800) 537-7697

*HCH1351*

WHITE COPY – MEDICAL RECORDS
YELLOW COPY – PATIENT