

USE OFFICIAL COUNTY/FACILITY LETTERHEAD FOR OUTSIDE CORRESPONDENCE

**LETTER RESPONDING TO REQUEST
FOR ACCESS TO PROTECTED HEALTH INFORMATION**

{Date}

{Patient's name}

{Address}

Medical Record #: _____

Dear {Mr./Ms.}

Thank you for submitting your **Request for Access to Protected Health Information**. Your request was forwarded to the responsible health care provider for review.

We received your written request, on _____, to access your protected health information. We have determined that:

- Your request has been granted, and the information is included with this letter. The cost for this service is \$_____, based on a charge established by the California Health & Safety Code 123110(b).
- Your request has been granted, and the following appointment time has been scheduled to for your record review:

Date: _____

Time: _____

Location: _____

If you have any questions or need to reschedule, please contact us at (PHONE NUMBER).

- We will grant your request to access, but only in part (see below regarding the reason for partial denial). We will provide access to the following health information:

REASON FOR DENIAL (if applicable). Your request to access your protected health information is denied because:

- You are not legally authorized access to the health information.
- We are not permitted to release health information regarding information compiled in anticipation of or use in a civil, criminal, or administrative action or proceeding. This denial is not subject to the right to review.
- You did not provide all the information we need to complete your request. Please provide the items listed and return to us.

- ❑ You were unable to provide satisfactory personal identification to access your own information.
- ❑ You were unable to provide satisfactory personal identification as proof of status as a patient's representative (parent, guardian or conservator).
- ❑ Other:

REQUEST FOR REVIEW OF DENIAL OF ACCESS (if applicable): If we denied your request to access your protected health information, in whole or in part, you may submit a **Request for Review of Denial of Access of Health Information**, included with this letter. After completing the form, return it to the DHS facility.

For more information about your health privacy rights, ask a staff member for a copy of our **Notice of Privacy Practices**. You may also obtain a copy by visiting our website at <http://www.dhs.co.la.ca.us/>.

If you believe your privacy rights have been violated, you may file a complaint with us, Los Angeles County or the Federal Government. You will not be penalized or retaliated against for filing a complaint. To file a complaint with us, or if you have comments or questions regarding our privacy practices, contact facility administration or any of the following offices:

**Los Angeles County Department of Health Services
Privacy Officer
313 N. Figueroa Street, Room 708
Los Angeles, CA 90012
800-711-5366**

**Los Angeles County Chief Information Office
Chief Information Privacy Officer
500 West Temple Street, Suite 493
Los Angeles, CA 90012
(213) 974-2164
Email: CIPO@cio.co.la.ca.us**

Thank you for providing us with this opportunity to assist you and we look forward to continuing to serve your healthcare needs.

Sincerely,

{Facility Representative}
Program / Unit Manager
Facility Address