

**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 <input type="checkbox"/> REQUEST TO AMEND RECORD <input type="checkbox"/> REQUEST TO INSPECT/COPY RECORD <input type="checkbox"/> 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