Tuscola County Health Department (TCHD)
Request for Review of Denial of Access to Protected Health Information (PHI)

Date of request for review: _____

Individual's name: _____

Birth date: _____

Social Security #: _____

Patient address: _____

I hereby request a review of the decision to deny me access to Protected Health Information requested by me on: _____ **(date)**

Signature of Individual or Personal Representative: _____

Relationship to Individual: _____

For Tuscola County Health Department Use Only:

Date Received: _____

Previously withheld information to be provided to the individual

☐ **All** ☐ **some** ☐ **none**

Reason for withholding information: _____
_____
_____

Name of Staff Member: _____

Title: _____

Signature of Healthcare Practitioner: _____

Date: _____