LOUISIANA
DEPARTMENT OF
HEALTH

Denial of Restriction Request

Insert Client Name and Address	Medicaid ID# or Soc. Sec. #
	Date Filed
	Date Processed

Dear(Client name):

Thank you for submitting your "Restriction of Use and Disclosure Request Form."

Your request has been denied for the following reason(s) (Use additional sheets, if necessary):

If you disagree with all or part of this denial, you may file a written statement of disagreement with:

Office/Facility Name:_____

Address:_____

_____

Telephone Number: (   )_____

Agency Representative/title: _____

Sincerely,

Name
Job title

c: Case file
       Program Privacy Office

Sample Form: The Program / Office mailing address must be added.