LOUISIANA DEPARTMENT OF HEALTH

Statement of Disagreement for Denial of Restriction Request

Name:	Date:
Mailing Address:	Date of Birth:
City/State/Zip:	Medicaid ID # or Soc. Sec.#:

I disagree with the decision to deny my request to restrict my protected health information because:

_____ _____

Signature of Individual or Personal Representative Authorized by Law — Date

_____ _____

Signature of Witness (If signed with "X" or mark) — Date

Return this form to: _____

_____

_____

LDH USE ONLY

Date received: _____ ❒ **Rebuttal** ❒ **No Rebuttal**

Comments:

_____ _____

Signature & Title of Agency Representative — Date