Southwestern District Health Unit
227 16th Street West
Dickinson, ND 58601-4675
Phone (701) 483-0171 or 1-800-697-3145 Fax (701) 483-4097

REQUEST TO ACCESS CONFIDENTIAL INFORMATION

1. Client Name: _____
2. Client Date of Birth: _____
3. Client Address: _____
4. Describe what Confidential Information you would like to have access to. Include dates if possible: _____
   _____
5. What format would you like this information to be in? _____
   _____
6. The agency may find it necessary to summarize the information you requested. Is that acceptable to you? _____
   _____
7. The agency may honor your request or deny it. Under some circumstances you may have the denial reviewed. If you request is denied, we will furnish you with the appropriate information.

_____ _____
Signature of client or legal representative Date

For Healthcare Organization Use Only

Access has been: _____ Granted _____ Denied
Reason for denial: _____
Can this denial be reviewed: _____ Yes _____ No
Date client notified: _____

- Letter must include basis for denial
- Statement of Client's Right to Review
- How to review if applicable
- Explanation of complaint procedure
- Title and phone number of complaint contact

Comments: _____
_____

_____ _____
Signature of Staff Person Date

_____ _____
Signature of Department Head Date

_____ _____
Signature of Executive Officer Date

Effective 4/2003; Updated 6/2016