Stormont-Vail HealthCare

Patient Restriction Request Form

Person(s) requesting restriction: ____

From whom is the information to be restricted? ____
Relationship: ____
Address: ____

Stormont-Vail Regional Health Center ____ Cotton O'Neil Clinic ____
See Notice of Privacy Policy for list of clinics

Dates of the information to be restricted (date of visit, date of procedure, and other services):

____

____

Description of information to be restricted (e.g., medical record, lab results):

____

____

What is the reason for requesting restriction?

____

____

Signature of patient or legal representative: ________________________________ Date __________

Relationship of legal representative to Patient:

____ Date ________________________

Request for Restriction of Protected Health Information
Stormont-Vail Health*Care*
Risk Management Department
1500 S.W. 10th Ave.
Topeka, KS 66604
785-354-6343 Privacy Officer
Fax 785-354-6302

Patient Name: ______________________________

Date of Birth: ______________________________

Today's Date: ______________________________