Patient Audit Request Form

Person(s) requesting audit: ____

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

Dates for the medical records audit (date of visit, date of procedure, and other services):
Beginning ______________________ End _______________________

Reason for the audit request (e.g.):
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Do you know of anyone who may have accessed the information in question:
Yes______ No_______

If yes, who? ____

Signature of patient or legal representative: ___________________________ Date____________

Relationship of legal Representative to Patient
____ Date __________

Request for Audit 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: _____________________________

For Stormont-Vail Health*Care* Use Only

Audit request initiated: ______________

Audit received from Information System: ______________

Comments: ____

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Privacy Officer: ________________________________Date: ___________________________________