

Patient Audit Request Form

Person(s) requesting audit: _____

Stormont Vail Hospital _____

Cotton O'Neil _____

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.):

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
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 Use Only

Audit request initiated: _____

Audit received from Information System: _____

Comments: _____

Privacy Officer: _____ Date: _____