Stormont Vail Health

Patient Restriction Request Form

Person(s) requesting restriction: ____________________

From whom is the information to be restricted? ____________________

Relationship: ____________________

Address: ____________________

Stormont Vail Hospital ____

Cotton O'Neil ____
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):

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

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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
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: ____________________