Patient Audit Request Form

Person(s) requesting audit: _____

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:

If yes, who?_____

Is this a concern regarding a Verbal Disclosure?

Yes _____ No_____

By whom and what information:

_____

_____

Signature of patient or legal representative:

_____ Date _____

Relationship of legal representative to patient:

_____ Date _____

Request for Amendment of Protected Health Information Stormont Vail Health Integrity & Compliance 1500 S.W. 10th Ave. Topeka, KS 66604 785-354-6343 HIPAA Privacy Officer Fax 785-354-6398	Patient Name: Date of Birth: Today's Date: