# 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 _____

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**Request for Restriction of Protected Health Information**

Stormont Vail Health
Integrity & Compliance
1500 S.W. 10th Ave.
Topeka, KS 66604
785-354-6343 Privacy Officer
Fax 785-354-6398

Patient Name: _____

Date of Birth: _____

Today's Date: _____