Stormont Vail Health | Cotton O'Neil

Please Mail Form to:
Stormont Vail Health
Special Contact Access
1500 S.W. 10th Ave., Topeka, KS 66606

Special Contact - Adult Patients

Step 1

Patient Name_____

Address_____ City_____ State_____ Zip_____

Date of Birth_____ Cotton O'Neil Physician_____ MRN_____

I hereby authorize **Stormont Vail Health / Cotton O'Neil** and designees to discuss the care and treatment, arrangements for care and treatment, or payment for care and treatment with the following individuals listed below who are involved with my care for the duration listed below. I understand that the provider may require a more specific release for certain information.

This permission is effective for a period of:

Only for the test or procedure specified_____

☐ One (1) Month ☐ Three (3) Years ☐ ____ Year(s)

Please print when completing form. All information is required.

Step 2

Who Can Access My Information: Name and Address	Date of Birth	Phone Number (with Area Code)	Relationship (No Abbreviations)
Name:			
Address:			
Name:			
Address:			
Name:			
Address:			
Name:			
Address:			

Step 3

I understand that I am responsible to notify Stormont Vail Health/Cotton O'Neil in writing to revoke or modify this request. Stormont Vail Health/Cotton O'Neil will make reasonable efforts to comply with this request. This form will supersede all prior requests unless otherwise indicated.

Patient Signature_____ Date_____Time_____

Staff Verification_____ Dept. _____ Date_____

Special Contact - Adult Patients (Continued)

Patient Name_____ Date of Birth _____

Please print when completing form. All information is required.

Step 2

Who Can Access My Information: Name and Address	Date of Birth	Phone Number (with Area Code)	Relationship (No Abbreviations)
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