Stormont Vail Health

Cotton O'Neil

Please Mail Form to:
Stormont Vail Health
Special Contact Access
1500 S.W. 10th Ave., Topeka, KS 66604

Special Contact - Minor Patients 0-13

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 above child 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: ☐ One (1) Month ☐ Until Age 14

Only for the test or procedure specified_____

Please print when filling out 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:			

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.

Parent/Representative

Signature (required)_____ Date_____Time_____

***NOTE:** If signed by a parent or personal representative, documentation regarding the person's legal authority must be verified and placed in the chart, *e.g.* Letters of Guardianship; Durable Power of Attorney for Health Care. Print the person's name and note the relationship to patient here:

Parent/Representative
(Print Name)_____ (Relationship)_____

Staff Verification_____ Dept. _____ Date_____

Special Contact - Minor Patients 0-13 – (Continued)

Patient Name_____ Date of Birth _____

Please print when filling out form. All information is required.

Step 2

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