Patient Accommodations Request Form

Patient Name: _____

Patient Address: _____

Patient DOB: _____

Requestor Name: _____

Requestor Phone Number: _____

Requestor Relationship to Patient: _____

Accommodations being requested (Change of Address, Access, etc.):

Records that need the accommodation:

Begin date of Accommodation: _____

End date of Accommodation (If permanent leave blank): _____

Signature of Patient or Legal Representative:

_____ Date: _____

Printed Name of Legal Representative (if applicable):

Relationship of Legal Representative to Patient:

Please send all patient HIPAA Requests to: **HIPAA Privacy Office** Stormont Vail Health Integrity and Compliance 1500 S. W. 10th Ave. Topeka, KS. 66604 Office: 785-354-6343 Fax: 785-354-6398 E-mail: Privacy@stormontvail.org	Patient Name: _____ Date of Birth: _____ Date of Request: _____