Patient Audit Request Form

Patient Name: _____

Patient Address: _____

Patient DOB: _____

Requestor Name: _____

Requestor Phone Number: _____

Requestor Relationship to Patient: _____

By signing below, I acknowledge that I am requesting an access audit of my Protected Health Information ("PHI"). I acknowledge that access audits are performed for a specific purpose, as I have outlined below, and not for a generalized purpose. Following the audit, a letter will be mailed to you regarding the audit findings.

Reason for the Audit Request:

_____

_____

_____

_____

Do you know of anyone who may have accessed the information in question?

_____

Is this concern regarding a Verbal Disclosure?

Yes: _____ No: _____

Begin date of Audit: _____

End date of Audit: _____

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: _____