Patient Restriction Request Form

Patient Name: ____

Patient Address: ____

Patient DOB: ____

Requestor Name: ____

Requestor Phone Number: ____

Requestor Relationship to Patient: ____

By signing below, I am requesting the implementation of a restriction on the use and disclosure of my Protected Health Information ("PHI") as I have described below. I understand that this request may be denied. I acknowledge that the restriction, if implemented, will not apply in the case of an emergency. This request will go in to effect upon approval and will continue indefinitely unless I submit a revocation in writing.

From Whom is the PHI to be restricted?

____

Description of the PHI to be restricted (medical record, lab results, etc.):

____

____

____

Date(s) of Service for PHI to be restricted: ____

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: ______________________