Audit Request Form

- Please complete this form with as much information as possible. Fields indicated with an asterisk (*) are mandatory fields. This will help Sinai Health (SH) fulfill your request.
- SH only accepts requests from the patient or someone authorized to make a request for the patient (i.e. substitute decision maker). You will be required to provide proof of your identity.
- Mail, email or fax the completed form to the SH Privacy Office:
  - Mail: 600 University Avenue, Room 1291
Toronto ON M5G 1X5
  - Email: privacyoffice@sinaihealth.ca
  - Fax: 416-586-5280

If you have questions, please contact the SH Privacy & Information Access Office at 416-586-4800 ext. 2101 or email privacyoffice@sinaihealth.ca with your name and phone number.

Part I – Patient Information		
*First and Last Name:		*OHIP or Medical Record #:
*Date of Birth:	*Telephone #:	
*Address:		
*City:	*Province:	*Postal Code:
* ☐ I have attached a copy of the patient's identification issued by a federal, provincial, municipal or state authority (i.e. driver's licence, health card, passport)		I give permission for SH Privacy to leave a voicemail at the number above: ☐ Yes ☐ No
Part II – Substitute Decision Maker Information (if applicable)		
First and Last Name:		Telephone #:
Address:		
City:	Province:	Postal Code:
☐ I have attached documentation demonstrating that I am the patient's substitute decision maker (e.g. Court order for Guardianship, Power of Attorney for Personal Care)		I give permission for SH Privacy to leave a voicemail at the number above: ☐ Yes ☐ No

Part III – Request Details

In order to run an audit on your electronic records, you must specify the timeframe. The audit report that is produced will show all accesses to your record from the date you indicate as the *Start Date* to the date you indicate as the *End Date*.

*Start Date (dd/mm/yyyy):

*End Date (dd/mm/yyyy):

Personal health information may be stored in a number of different electronic systems that can be audited, including SH systems and electronic systems shared with organizations outside of SH. Your information can be audited in different ways depending on the system. Each patient request will be evaluated on a case-by-case basis.

Please provide a description of your request below. Be as specific as possible, including the name(s) of individual(s) you believe may have accessed your records inappropriately, if applicable.

☐ I have attached additional details regarding this request.

Part IV – Understanding & Authorization

- I am aware that there may be fees associated with requesting copies of my audit report. These fees are in accordance with SH's Release of Information Fee Schedule.
- I understand that if inappropriate access is suspected, SH has a legal requirement to investigate. This investigation will include interviewing the suspected individual about access to your records.
- I understand that if inappropriate access to my record is confirmed, SH is required to take action against the person responsible, including but not limited to, termination, suspension, reporting to applicable regulatory colleges, and reporting to the Information and Privacy Commissioner of Ontario.

*Signature of Patient/Substitute Decision Maker:	*Date (dd/mm/yyyy):