Audit Request Form

- Please complete this form with as much information as possible. Fields indicated with an asterisk (*) are mandatory fields. This will help the University Health Network (UHN) fulfill your request.
- UHN 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.
- Send the completed form and proof of your identity to the UHN Privacy Office in one of these ways:
  - Mail: UHN Privacy
    190 Elizabeth Street
    R. Fraser Elliott, 2nd Floor
    Toronto, Ontario
    M5G 2L3
  - Email: privacy@uhn.ca Please note that email is not a secure method to communicate private information. It can be sent to the wrong recipient, intercepted and/or copied. **If you decide to send us your request and documents via email, you are acknowledging and accepting this risk.**
  - Secure File Transfer: Using https://fileshare.uhn.ca encrypts your documentation. Follow the instructions on the website.
- If you have questions, please contact the Privacy Office at 416-340-4800 ext. 6937 or email privacy@uhn.ca.

Part I – Patient Information		
*First and Last Name:		* UHN Medical Record #:
*Date of Birth:	*Telephone #:	Email Address:
*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 UHN 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 UHN Privacy to leave a voicemail at the number above: ☐ Yes ☐ No

Part III – Request Details

Please specify the requested audit timeframe. The audit report 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 UHN systems and electronic systems shared with organizations outside of UHN. 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. If necessary, the Privacy Office will contact you to clarify your request.

☐ 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 UHN's Standard Release of information Fee Schedule.
- I understand that if inappropriate access to my record is suspected, the UHN has a legal requirement to investigate. This investigation may include interviewing the suspected individual about his/her access to your record.
- I understand that if inappropriate access to my record is confirmed, the UHN 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):
*Signature of Witness:	*Date (dd/mm/yyyy):