SYSTEMS AUDIT REQUEST FORM
PERSONAL HEALTH INFORMATON

Type of Audit Request: ☐ **Client Request *** ☐ **Internal Request**

*Client's Name:

Address:

Telephone #: MCP #: Date of Birth:

Time Period Requested:

Brief Explanation of Request:

Signature of Requestor: **Date of Request:**

*** <u>FOR CLIENT REQUEST ONLY:</u>**
If the person requesting a Systems Access Audit is not the client, state the relationship and authority to do so. There is a fee associated with an audit request.

Signature of Authorized Representative **Relationship**

Please complete and forward to:

Privacy Office
James Paton Memorial Regional Health Centre
125 Trans Canada Highway
Gander NL A1V 1P7
Tracey.Steele@centralhealth.nl.ca