

**Organization Details**

Requesting Organization and Site (where applicable): \_\_\_\_\_

Requestor: \_\_\_\_\_ Role: \_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_

Name and Email of Privacy Officer (if different from Requestor ): \_\_\_\_\_

Date Request Submitted: \_\_\_\_\_ Requested Return Date: \_\_\_\_\_

**Systems Supporting User Access to PHI Audits: Select Applicable System**

South and  
Western DIR  
(SW DIR)

Central and  
Eastern DIR  
(CE DIR)

North and  
Eastern DIR  
(NE DIR)

OCINet Picture Archiving  
and Communication  
System (OCINet Agfa EI  
PACS)

Emergency Neuro  
Imaging Transfer  
System (ENITS)\*

**Type of Access to PHI Audit Requested:**

**Access to Specified Exam(s)** – report of all accesses to specified exam(s) by any user within a timeframe

**Access by Specific User** – report of all accesses to PHI by a specified user within a timeframe

**Access to a Specific Patient** – report of all accesses to PHI of a specified patient by any user within a timeframe

**Other** – please use notes section to provide details. Our office will follow up where required

**Type of Transfer of PHI Audit Requested:**

**Exam(s) transferred to the DIR** – exams and related information contributed to the DIR by the requesting participant

**Exam(s) transferred to Participants' local PACS via Foreign Exam Management (FEM)** – copies of prior exams  
retrieved by OCINet participants through automated transfer or ad hoc query

**Exams transferred from the DIR to external systems** - copies of exams and related information transferred on behalf of  
the contributing participant, as authorized.

**Select scope of transfer to be audited. Use notes to provide more detail or contact the privacy office to discuss.**

All PHI transferred in a specified timeframe

Specific exam(s) or patient information

**Notes Related to Audit Request:**

**Requested Audit Time Period (Required)**

Start Date: \_\_\_\_\_ Stop Date: \_\_\_\_\_

**Required Audit Information (\* indicates mandatory field)**

Please provide the following information as relevant to the type of audit requested above

**Patient Information**

First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_ Last Name\*: \_\_\_\_\_

HCN\*: \_\_\_\_\_ MRN\*: \_\_\_\_\_ DOB\*: \_\_\_\_\_

**User Information**

User First Name: \_\_\_\_\_ User Last Name: \_\_\_\_\_

User Email Address: \_\_\_\_\_ UserName in System: \_\_\_\_\_

**Exam Information**

Please also provide patient information above for this type of audit

Accession #: \_\_\_\_\_

Accession #: \_\_\_\_\_

Accession #: \_\_\_\_\_

Accession #: \_\_\_\_\_

Accession #: \_\_\_\_\_

\* Please note, the Emergency Neuro Imaging Transfer System (ENITS) provides timely access to urgent and emergent images to specialized healthcare providers. Imaging data in ENITS is retained for less than 14 days.

Please contact the Privacy Office for any questions about privacy auditing,  
and to arrange for secure transfer of this form once completed.

**Please DO NOT email forms containing Patient Health Information.**

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