**Health and Medical Research Electronic Medical Record (EMR) Access Audit Request Form**

Please note: This is an electronic form and is designed to be completed online. All fields marked with an asterisk (\*) are required. Where ‘Select’ appears, please make a selection from the dropdown menu. If electronic signature is not available, please type in full name.

Email completed form to the Digital Health SA Security Investigations for processing via [DHSASecurityInvestigations@sa.gov.au](mailto:DHSASecurityInvestigations@sa.gov.au) addressed to the **Security Manager**.

*A limited number of Researchers undertaking health and medical research at authorised SA Health site(s) are granted access to EMR patient data for the duration of the research. As part of the process to grant access to EMR data, the researchers provide consent to the respective SA Health research office(s) to audit their activity on a regular basis to ensure appropriate governance is maintained while undertaking health and medical research at the SA Health site(s).*

*The audit will compare the researcher(s) access log of consenting patients, with the Digital Health data of actual patient records access by the researcher(s).*

*This Access Audit Request Form is an application for Digital Health SA to provide a list of patient information (first name, last name, unique record numbers (URNs) and date accessed) retrieved by the identified researcher(s) during prescribed time period.*

**Researchers’ Details and Access Audit Time Period**

**NB**: This section is to be completed by the Audit Requester.

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Surname | First Name | HAD ID | Position | Employee No | Location | Site(s) | Email | Audit Start Date | Audit End Date |
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**Access Audit Requester Details   
NB**: This section is to be completed by the Audit Requester.

|  |  |  |
| --- | --- | --- |
| \*Surname: | \*First Name: | \*HAD Username: |
| \*Position: | \*Contact Number: | \*Line Manager: |
| \*Department / Local Health Network: [dropdown selection] | | |
| \*Site (Primary): [dropdown selection] | | |
| Other: | Location: | |

**Access Audit Requester Signature**

**NB:** This section is to be completed by the Audit Requester.

|  |  |  |  |
| --- | --- | --- | --- |
| \*Full Name: | \*Email: | | |
| \*Signature: | | \*Date: | \*Phone: |

**Access Audit Request Authorisation**

**NB:** This section is to be completed by Clinical Trial Manager / Director of Research / Executive Director Medical Services.

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| \*Approved by (Name): | | \*Position: |
| \*Signature: | \*Date: | \*Phone: |