eHealth CyberSanté NB
Electronic Health Record
Dossier de santé électronique

# EHR ACCESS REQUEST BY EMR USER

*Department of Health / Electronic Health Record (EHR)*

**Tab to go from one field to another or click on the grey box beside each item.**

**Please submit the completed form to: EHRaccess@gnb.ca or fax completed form to: 1-506-462-2010**

## 1. USER INFORMATION – to be completed by the requestor

| | |
|---|---|
| **a. Full Name** (no nicknames) | |
| **b. Work Location/Clinic Name** | |

**c. EMR Information (REQUIRED in order for your request to be processed)**

**ASK YOUR EMR VENDOR STAFF FOR THE FOLLOWING INFORMATION IF YOU DO NOT KNOW IT:**

| EMR user ID (ALL CAPITAL LETTERS, NO NUMBERS) | EMR organization ID (4 digit number) |
|---|---|
| | |

| | |
|---|---|
| **d. Business Telephone Number** | |
| **e. Business Address** (Street and City) | |
| **f. Email Address** (Enter the email address to which you want to receive the link to the privacy training) | |

**g. Do you also work in an RHA facility or have you requested an account from the zone?**

☐ YES, please fill below

| | |
|---|---|
| **Facility/hospital name** | |
| **Employee Number**<br>If you are an employee of Horizon or Vitalité, you must provide your employee number. Note that employee numbers for Horizon staff are 8 digits long and 6 digits for Vitalité. | |
| **Zone/RHA AD Username**<br>**This is not your EMR User ID**. If you have access to ECP or a hospital system, you have an AD username to access those systems. If you are unsure what your AD username is, contact the SNB service desk for assistance. ALL PHYSICIANS have an AD account. | |

☐ NO, please fill below

| | |
|---|---|
| **Your mother's maiden name?** | |
| **A memorable date?** | |
| **Your favorite place?** | |

These responses will be used to validate your identity when you call to receive your username

**h. Role (select one only)**

**PRIMARY CARE PROVIDERS**

- ☐ **General Practitioner**
- ☐ **Medical Specialist**
  - **Specialty**:
- ☐ **Nurse Practitioner**

Are you a Locum ☐ Yes ☐ No

If yes, provide the dates of your Locum work:

**MEDICAL LEARNERS**

☐ **Resident** ☐ **Student**

Provide the date that you will complete your practicum/ work in New Brunswick:

**NURSE OR OTHER CLINICIAN**

- ☐ **Licensed practical nurse (LPN)**
- ☐ **Registered Nurse (RN)**
- ☐ **Other clinician** Please specify:

**OTHER STAFF**

- ☐ **Non-clinical staff**
  - ☐ Medical Office Administrator
  - ☐ Medical Secretary
  - ☐ Receptionist
  - ☐ Other, specify:

If you are a replacement and know the date you will leave the job, please specify:

**NOTE: For prescribers who prescribe monitored drugs and licensed pharmacists who dispense monitored drugs defined as "participants" by the Prescription Monitoring Act, this EHR access request represents an application to be registered in the Prescription Monitoring Program (PMP).**

## 2. USER ACKNOWLEDGMENT - To be completed, signed and dated by the requestor.

| I | | agree that: |
|---|---|---|
| | ENTER YOUR NAME (PRINT) | |

1. I understand that the personal health information (PHI) stored in the EHR is confidential and must only be used for providing or assisting in the provision of health care.
2. I understand I may not view or conduct searches for information about patients outside of my circle of care; including my own EHR record or the records of family members.
3. I must take reasonable steps to protect my EHR access information from unauthorized use.
4. I will not share my username, password or other EHR access information with anyone and I will use a complex password.
5. I am responsible for any unauthorized disclosure of personal information regarding clients/patients through the inappropriate use of my authorized access.
6. I will ensure that patient information is not made available to unauthorized individuals by way of printing,display, etc.
7. I understand that I will get a read-only access and printing is restricted to authorized users only.
8. I will not download personal health information to the hard drive on my work or personal computer(s) or any portable storage devices.
9. I will immediately notify the EHR Administrative office by e-mail if my account has been, or may have been, compromised in any way. E-mail address: EHRAccess@gnb.ca
10. I will notify the EHR Administrative office by email within 5 working days when it has been determined that access to the EHR is no longer required. EHRAccess@gnb.ca
11. The Department of Health may revoke my access if I fail to comply with my obligations outlined in this form.
12. The Department of Health may revoke my access if I have not logged into the EHR for a period greater than 4 months.
13. I understand that usage of the EHR will be monitored.
14. I understand that I will not be granted access to the EHR before I complete the online EHR privacy training.

**By signing below, I acknowledge that I have reviewed, understand, and agree to the above. I also understand that the Department of Health may revoke my access if I fail to comply with my obligations.**

| | |
|---|---|
| **Signature of requestor/user** | |
| **Date** | |
| **Language of choice for training?** | ☐ ENGLISH ☐ FRENCH |

## 3. PHYSICIAN AUTHORIZATION FOR OFFICE STAFF ACCESS INCLUDING RESIDENTS or CHC MANAGER FOR ALL CHC STAFF

I authorize the above named individual to have access to the EHR and declare that the individual has been authenticated to be the individual identified in section 1 of this form.

**I verified the following:**

a. All the needed information is complete and accurate;
b. The role selected is the individual's role within our organization;

and I will notify the EMR Administrator by e-mail within 5 working days when it has been determined that this user no longer requires access to the EHR. EHRAccess@gnb.ca

| | |
|---|---|
| **Physician or CHC Manager full name (PRINT)** | |
| **Physician or CHC Manager signature** | |
| **Date** | |

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If you have any questions about access, send an email to: EHRaccess@gnb.ca

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