EHR ACCESS REQUEST FOR PRIVATE SECTOR USER

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 the form to: (1-506) 462-2048

1. USER INFORMATION – to be completed by the requester	
a. Full Name	
b. Job Title	
c. Licence/Registration Number	
d. E-mail address (Enter the email address to which you want to receive the link to the privacy training.)	
e. Main Work Location – Pharmacy name or private practice/clinic name and the civic address (number and street) (If you work in more than one practice, provide name for the one where you spend the majority of your work hours.)	
f. City (Work Location)	
g. Second Work Location - Pharmacy name or private practice/clinic name	
h. Business Telephone Number	
i. Do you also work in a hospital? If yes, provide the facility name, your employee number and your userid when you connect to the network.	☐ YES Hospital Name Employee No UserId ☐ NO
j. Personal information (These 3 mandatory questions will be asked by the service desk to confirm your identification. Make sure you remember the answers.)	Your mother's maiden name? A memorable date? Your favorite place?

k. Role/Profession (select one only)

☐ Licensed pharmacist	☐ Dentist
☐ Chiropractor	☐ Optometrist
☐ Occupational Therapist - Private Sector	☐ Occupational Therapist - Public Sector
☐ Physiotherapist - Private Sector	☐ Physiotherapist - Public Sector
☐ Licensed Pharamcy Technician	☐ Other (specify):

l. Do you require access to the Public Health Information Solution (PHIS) ☐ YES ☐ NO

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 requester.

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, including verifying authorization to grant access with your regulatory or licensing body.
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 requester/user	
Date	
Language of choice for training?	☐ ENGLISH ☐ FRENCH

3. MANAGER AUTHORIZATION – To be completed by the requester's manager.

This authorization is not required for physiotherapists, occupational therapists or for managers of a pharmacy or a private practice/clinic.

I authorize the above named individual to get 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 your organization.

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

Manager's full name (PRINT)	
Manager's signature	
Date	
E-mail address	
Telephone number	

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