eHealth CyberSanté NB
Electronic Health Record
Dossier de santé électronique

EHR ACCESS REQUEST FORM

Private Sector

☐ New Request
☐ Information Update Request

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 the completed form to: 1-506-462-2010

1. USER INFORMATION – to be completed by the requester

a. Full Name	
b. Job Title	
c. License/Registration Number	
d. E-mail address (Enter the email address to which you want to receive communications and training.)	
e. Main Work Location – facility/clinic name and the full civic address (number, street, and city) (If you work in more than one practice, provide name for the facility where you spend the majority of your work hours.)	
f. Additional Work Location(s) - facility/clinic name(s)	
g. Business Telephone Number	
h. Do you also work in a hospital?	

☐ YES, please fill below		☐ NO, please fill below	
Facility/hospital name		Your mother's maiden name?	
Employee Number		A memorable date?	
UserID (used to access zone applications)		Your favorite place?	

i. Role/Profession (select one only)

- ☐ Chiropractor
- ☐ Dentist
- ☐ Licensed Pharmacist
- ☐ Licensed Pharmacy Technician
- ☐ Occupational Therapist
- ☐ Optometrist
- ☐ Physiotherapist
- ☐ Nurse Practitioner
- ☐ Registered Nurse
- ☐ Licensed Practical Nurse
- ☐ Other (Specify):

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

NOTE: For prescribers who prescribe monitored drugs and 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 business 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.
15. Notify the EHR Administrator by email at EHRaccess@gnb.ca when I no longer require access to the EHR and provide the reason why, such as:
    - Maternity Leave;
    - Sick leave over one month;
    - Educational leave;
    - Retirement or end of employment; or
    - Any other leave with a duration of 3 months or more.

    If applicable, provide the date I intend returning to work.

By signing below, I acknowledge that I have reviewed, understand, and agree to the above. I recognize that being granted access to the EHR is a privilege and that the Department of Health is required to control access to the personal health information it contains. 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/employer (if applicable)

I authorize the above named individual to obtain 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.

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

Manager's full name (print)	
Manager's job title	
Manager's signature	
Date	
E-mail address	
Telephone number	

4. ACCESS CONTROL AGREEMENT – To be completed if you do not have a manager

The following individual can be contacted by the Department to verify that I still require access to the EHR. In the event that I cannot notify the Department before leaving my job temporarily or permanently, this individual will contact the Department regarding the situation:

Contact name (print)	
Relationship with EHR User	
E-mail	
Phone number	
Contact signature	
Date	
EHR User signature	
Date	

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

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