PART A: USER INFORMATION

The Information collected on this form will be used in support of operation of the Electronic Health Record (EHR), HEALTHe NL, including user identification, account management and auditing. This information may also be used for planning and analytics purposes.
***Once the form has been completed it must be signed/witnessed by your Manager/User Administrator.**

User Information			
Last Name	First Name	Middle Initial	Position/Title
Date of Birth (YYYY-MM-DD)		License number (if applicable)	
Primary Facility / Site Name		Department/ Clinic/ Service	
Mailing Address		City/Town/Postal Code	
Business Phone	Mobile Phone (FOR IOR)	Email (FOR IOR)	

☐	By checking this box I am indicating that I have been informed of HEALTHe NL training and education material provided by the NL Centre for Health Information.

PART B: CONFIDENTIALITY AND ACCEPTABLE USE

Acceptable Use:
You agree to not access, collect, use, or disclose any clinical or other personal health information maintained in HEALTHe NL for any purpose or in any way other than those authorized under appropriate legislation, policies, and standards of practice.

You agree that you will not use HEALTHe NL for an illegal or improper purpose, or take steps that would have a negative impact on the security, integrity or functioning of the HEALTHe NL viewer.
Confidentiality:

You agree to treat as confidential all information collected, used and disclosed in association with the HEALTHe NL viewer, whether verbal or written, and will not participate in or permit the unauthorized release, publication or disclosure of that information to any person, corporation or other entity under any circumstances except as authorized by legislation, policies, and standards of practice.

PART C: PASSWORDS

Passwords: You agree to keep your password absolutely confidential; it is for your use alone. You agree not to distribute or share your username and password with anyone.

If your password becomes known: You agree that if you suspect someone else knows your password you will notify the Centre's Service Desk at 1-877-752-6006 or in person at 70 O'Leary Ave. St. John's as soon as possible and follow the instructions given to you by the Centre.

PART D: HEALTHe NL Users Disclosure

I am aware that the HEALTHe NL consolidates information from various source systems province-wide. While efforts are made to ensure accuracy and completeness, HEALTHe NL is not exhaustive and should not be relied upon as a sole information source in providing care. Patient data may exist in other RHAs, community health, private clinics or pharmacy databases. I recognize accepting a password gives me authorized access to confidential electronic information.

PART E: SIGNATURES

This agreement outlines your responsibilities regarding the access, use and disclosure of the personal health information contained within HEALTHe NL. Additional information on the Personal Health Information Act can be found at http://www.health.gov.nl.ca/health/PHIA/. By signing below you agree that you understand and agree to comply with above terms/conditions and that all information provided during the registration process is accurate and true.

If you have any questions, please contact your regional Change Management Representative, or the Centre's Service Desk at 1-877-752-6006.

_____

User Legal First and Last Name (Please Print)

_____ _____

Signature Date

_____

User Administrator/Manager First and Last Name (Please Print)

_____ _____

Signature Date

Please scan/email all registration forms to Tonya Ryan tonya.ryan@centralhealth.nl.ca or via fax (709) 292-2386.