



## eACCESS REGISTRATION FORM

PO Box 2200, Halifax, NS, B3J 3C6  
T: 902-496-7123 TF: 1-877-476-7767  
F: 902-481-3157  
E: [pmp@medavie.bluecross.ca](mailto:pmp@medavie.bluecross.ca)

### Section A: Contact Information

Surname:		First Name:	
Provider Type: <input type="checkbox"/> Physician <input type="checkbox"/> Dentist <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Pharmacist		Provincial License Number:	
Business Mailing Address:			
Business Telephone Number:	Fax Number:	Email Address:	

### Section B: Authorization

IN ORDER TO QUALIFY FOR EACCESS, ALL FORMS MUST BE COMPLETED ACCURATELY. INCOMPLETE FORMS WILL NOT BE PROCESSED. **THE E-MAIL ADDRESS IS MANDATORY AND MUST BE A SECURE E-MAIL ADDRESS TO WHICH ONLY THE PRESCRIBER OR PHARMACIST NAMED ABOVE HAS ACCESS.** PLEASE ENSURE THE CONFIDENTIALITY AGREEMENT IS SIGNED AND INCLUDED WITH THIS APPLICATION.

*I CERTIFY THAT I AM IN GOOD STANDING WITH THE PROVINCIAL LICENSING BODY AND THAT THE INFORMATION GIVEN ON THIS APPLICATION FORM IS ACCURATE.*

Please indicate with an **X** if you **do not** want the NSPMP to use the above indicated email address for the purpose of sending Program communication such as Bulletins, Alert Notices, etc.

Signature:	Date:
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## Nova Scotia Prescription Monitoring Program eAccess User Agreement

### **PART A: CONFIDENTIALITY AND ACCEPTABLE USE**

1. I understand that it is my duty to adhere to the provisions of the Nova Scotia Prescription Monitoring Program's (NSPMP) policies and procedures, and agree to same.
2. I understand that all personal health information to which I have access is confidential, and is not to be discussed with or communicated to anyone who is not authorized to know the information in any manner, except as in accordance with the NSPMP's policies and procedures regarding same.
3. I will not access nor use personal health information except as it is necessary to perform my duties and/or as I am authorized to do so by the NSPMP.
4. I will not disclose personal health information to any unauthorized person, allow any unauthorized person to access personal information, nor discuss personal information with, or in the presence of, any unauthorized person.
5. I will immediately report any breaches of privacy and/or confidentiality to the NSPMP.
6. I understand that it is my responsibility to secure information to which I have access in accordance with the policies and procedures of the NSPMP governing the security of information.
7. I understand that if I have questions or concerns respecting access, disclosure or use of personal information, I am responsible for addressing those questions or concerns with the NSPMP.
8. Should I inadvertently breach any of the provisions of the NSPMP's policies regarding the access, disclosure or use of personal health information, or cause a security breach which could lead to improper disclosure of information held by the NSPMP or improper access by others to information held by the NSPMP, I understand that a record of this breach will be maintained by the NSPMP and that I may be required to undertake additional privacy and security education.
9. Should I wilfully breach any of the provisions of the NSPMP's policies respecting the access, disclosure or use of personal information or cause a security breach which could lead to improper disclosure of information held by the NSPMP or improper access by others to information held by the NSPMP, I understand that I may have access revoked and/or face disciplinary action with my licensing authority.

### **PART B: PASSWORDS**

**Passwords:** You agree to keep your password absolutely confidential; it is for your use alone. You will not share your password.

**If Your Password Becomes Known:** If you suspect that someone else knows your password you must notify the Prescription Monitoring Program at 902-496-7123, or toll free at 1-877-476-7767 immediately.

**Responsibility for Losses:** You are responsible for any and all uses of the eAccess secure website associated with your password.

**I have read and understand this user agreement.**

Dated at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_

Signed: \_\_\_\_\_ Print Name: \_\_\_\_\_

Witness: \_\_\_\_\_ Print Name: \_\_\_\_\_