FORM A

Request for Remote Access to Health Sciences North (HSN)
Hospital Computer Information System (HCIS)

PURPOSE OF THIS FORM

This form is to be filled out legibly and in its entirety, and submitted to HSN's Privacy Office in order to approve the Organization and grant remote user access to HSN's HCIS.

Health Information Custodian (HIC) Requesting Access

Organization/Physician's name:	
Address:	
Phone Number:	Fax Number:
Office e-mail:	

HIC's Privacy Officer or Delegate (Authorized Requester) This person can be same as above.

Name:	Title:
Phone Number:	Alternate Number:
Fax Number:	Office e-mail:

Responsibilities of the HIC's Authorized Requestor

1. Monitor the access of remote users.
2. Review user activity logs quarterly or at the request of HSN.
3. Provide HSN's Privacy Office (PO) with a list of active users every 6 months.
4. Notify HSN's PO when a user requires an extension beyond the initial expiry date provided.
5. Notify HSN's PO immediately of any remote user accounts that require termination.
6. Ensure that all remote users of the HIC have signed the *Request for Remote Access to HSNs HCIS – Form B*.
7. Ensure that all remote users review the training material provided and understand that access to HSN's HCIS is only permitted for the provision of care.

Ensuring Compliance with Legislated Requirements

1. HSN will not permit access to its HCIS to any users that have not signed the Remote User Agreement.
2. HSN will conduct regular audits on remote users to ensure compliance.
3. If any remote user activity is unauthorized, HSN will terminate the user's access to the HCIS immediately. If HSN determines that a remote user has accessed PHI that he/she was not authorized to access, HSN reserves the right to terminate the user's access immediately and permanently.
4. The HIC responsible for the remote user will be responsible for complying with PHIPA in the event of a privacy breach.
5. The HIC is responsible for cooperating with HSN and participating in all breach investigations that involve their staff/agents.

PATIENT PRIVACY AND CONFIDENTIALITY

The parties expressly acknowledge that both **HSN** and _____
(Name of organization)
(***hereafter identified in this document as the*** **"applying organization"**) are Health Information Custodians and that pursuant to the Privacy Laws, **HSN** and the **applying organization** are subject to various obligations and prohibitions including, without limitation, obligations and prohibitions relating to the collection, use, disclosure, retention and safeguarding of Personal Health Information. Notwithstanding anything herein contained, **HSN** and the **applying organization** agree to comply with all laws and regulations affecting or pertaining to patient privacy and confidentiality, including without limitation, the Privacy Laws, and nothing in this Agreement will restrict or limit in any way compliance by either of **HSN** and the **applying organization** with the Privacy Laws.
The Health Information Custodian is responsible for the actions of its agents.
For the purpose of this Section:
(a) **"Personal Health Information"** has the same meaning as in the *Personal Health Information Protection Act*, 2004 S.O. 2004 c.3;
(b) **"Health Information Custodian"** has the meaning as in the *Personal Health Information Protection Act*, 2004 S.O. 2004 c.3
(c) **"Privacy Laws"** means any and all federal and/or provincial statutes or regulations now or in future in force relating to the protection and/or privacy of Personal Information, Personal Health Information and/or Quality of Care Information, including without limiting the generality of the forgoing, the *Personal Information Protection and Electronic Documents Act* (Canada), the *Personal Health Information Protection Act, 2004* (Ontario), and the *Quality of Care Information Protection Act, 2004* (Ontario)

By signing this form you indicate that you accept responsibilities as the Organization's Authorized Requestor and agree to ensure that all remote users comply with legislated requirements.

Signature of authorized requestor:	Date:

E-mail form to: privacyoffice@hsnsudbury.ca
OR
Fax completed form to: (705) 523-7075 with attention to Privacy Office
OR
Mail completed form to: Health Sciences North/Horizon Santé-Nord
Sudbury Outpatient Centre - Privacy Office
865 Regent St South
Sudbury, Ontario P3E 3Y9

HSN USE ONLY

Date Received:	Date Approved:
Authorized Requestor:	Telephone Number:
Email:	Fax Number:
HSN Privacy Office Signature:	

Health Sciences North
Horizon Santé-Nord