# **SIGN-UP PROCESS DOCUMENT FOR ACCESS TO Health Connect South (HCS) and associated databases e.g. éclair**

#  ***Including limited access to HealthOne e.g. medications***

I require access to the electronic health records at the DHB for the purposes of performing my clinical duties

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** |  | **Role:** |  |
| **Contact Details:** |  | **Registration Body:** |  |
| **Drivers Licence/Passport Number:***(Copy of ID* ***must*** *be Attached)* |  | **Registration Number:** |  |

I confirm that:

* I will only access records of those patients when I am involved in their clinical care or as part of a quality assurance activity
* When I am in direct contact with the patient I will ask and obtain agreement for their information to be accessed by health providers
* I understand that my access may be audited and undertake to participate in audit activities as required by the DHB
* I understand that should I access records inappropriately that the consequences may be severe and include removal of access privileges and being reported to my professional registration body
* I undertake to actively contribute records and information to the shared clinical record when this becomes technically possible in the future

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Verification process (at DHB) completed by:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Designation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_