Provincial Health Services Authority
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BC Provincial Blood Coordinating Office

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iCHIP PHM User Agreement & Access Form - Patient

This form is to request access to the Patient Home Module (PHM) of the Inherited Coagulopathy and Hemoglobinopathy Information Portal (iCHIP). PHM access will allow the entry of infusion records and assist with patient self management.

Privilege Management and Access Control

Patients, their parent or legal guardian or their substitute decision maker can authorize additional user accounts to access the patient's records in the PHM. It is their responsibility to notify the clinic support staff when these user accounts need to be deactivated. Deactivation notification must be made in writing and submitted to the clinic support staff.

Account Information

A. Patient Information

Last Name: _____ First Name: _____

Date of Birth: _____ PHN: _____

B. Account User Information

Why are your cellular number and cellular provider required?
In order to protect your privacy and the confidentiality of your personal information*, we need to verify that you are the person accessing iCHIP using a 2-step verification process. This process protects your account with something you know (your password) and something you have (your phone).
When accessing iCHIP using the desktop application from a new location, a verification code is sent via text message to your cell phone for you to enter when logging in. If you do not have a cell phone or do not use text, you will be required to contact the clinic for verification.
When accessing iCHIP using the mobile application from a new device, a verification code is sent via text message to your cell phone and via e-mail for you to enter when logging in.

Last Name: _____ First Name: _____

Phone Number: _____ Email: _____

Cell Number: _____ Cellular Provider: _____

Postal Code: _____ Relationship to patient: _____

C. Person Legally Qualified to Authorize (Complete below if patient is NOT the account user)

I authorize the Account User described above to have access to the patient's PHM account. I am aware that this will provide access to the patient's personal information*.

_____ _____
Name of person legally qualified to authorize user access

Signature of person legally qualified to authorize user access

_____
Relationship to patient

Date: _____ Phone: _____

* personal information includes: name, birthdate, diagnosis, contact information (telephone numbers/emails/addresses), immunizations, allergies, infusion records and product inventory.

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All iCHIP PHM System Users are subject to the following terms and conditions:

- I will keep my username and password confidential and not share this information with anyone.
- I will only use my own user account to access iCHIP PHM.
- I will ensure that there is an anti virus protection service on my computer.
- I will take reasonable care to protect the security of the user information and will immediately notify the clinic if:
  - account information is lost or stolen
  - any potential or actual unauthorized disclosure of information
- I am aware that it is recommended when using iCHIP on a mobile device to password or PIN protect the device, enable auto-lock when not in use and ensure the operating system and iCHIP application are up-to-date.
- I am aware when using the mobile application that although the database saved on my mobile device is encrypted, there is a risk of storage and disclosure of the database outside of Canada if partial or full content of the local drive of my mobile device is backed up to the cloud (e.g. iCloud, Dropbox, etc.).
- I have read and agree to the Terms of Use in iCHIP (www.ichip.ca/phm-help/terms.html). I am aware that non-compliance may result in the deactivation of the account.
- In the case of a minor patient, I have not been denied periods of physical placement with the Child and there are no court orders or restraining orders in effect limiting my access to the Child's records.

D. Request to initiate patient account - To be completed by Account User

By signing this form, you are confirming that all information you have provided is true to the best of your knowledge and you agree to the Terms of Use above and in the PHM. Providing false information or non compliance with the Terms of Use may result in immediate termination of your access privileges.

I agree to comply with the terms and conditions listed above.

Name: _____ Signature: _____

Date: _____

E. Request for iCHIP user Account - To be completed by Authorizing Clinic Nurse

Name: _____ Signature: _____

Date: _____ PHM Profile Edit Privileges: ☐ Yes ☐ No

iCHIP Patient ID: _____

F. Account Creation Information - To be completed by Clinic Support Staff

User added to iCHIP? ☐ Yes ☐ No

Expiry Date added (if applicable)? ☐ Yes ☐ No

User Name: _____

Authorizing Person ID Reviewed (non patients): ☐ Yes ☐ No

User Notified by: ☐ Phone ☐ Fax

Completed by: _____ Date: _____

G. Account Deactivation

☐ Disable User

Authorized by (name): _____

Completed by: _____

Authorized Date: _____

Authorized Signature: _____

Completed Date: _____