# eDOCSNL Program Termination/Withdrawal Notification

As per your signed Physician Participation Agreement section 5.0 and 6.0, to initiate the process to terminate/ withdraw from the eDOCSNL program, please complete the steps below.

### Termination/Withdrawal Information:

- The participating provider **must** provide 90 days written notice to Newfoundland and Labrador Centre for Health Information (NLCHI) that he/she wishes to withdraw from the eDOCSNL program.
- The participating provider **acknowledges** that upon the effective date of withdrawal from participation in eDOCSNL, he/she will no longer be entitled to access, use or disclose EMR data using Med Access.
- The participating provider is **responsible** for meeting all requirements of the College of Physicians and Surgeons of Newfoundland and Labrador, including Bylaw 6: Medical Records.
- The participating provider must communicate, through this application, how data in their EMR is to be handled/transferred.
- NLCHI will inform TELUS of provider's intent to exit eDOCSNL Program.
- TELUS will contact the provider to discuss data extraction options, processes and associated costs. The provider is **responsible** for all costs associated with their data extraction.
- The participating provider is **responsible** to pay any outstanding eDOCSNL program or service fees

### Step 1: Acknowledgement of Termination/Withdrawal

I, _____ am requesting to terminate my participation in eDOCSNL by delivering this written Notice of Termination to the EMR Program Director. By submitting this application I am initiating my 90 day termination notice period with NLCHI.

### Step 2: Format and Manner of Data Transfer

As per the Personal Health Information Act S. 4(3) and the Physician Participation Agreement section 22.1 data can be transferred using either data export, electronic printout, assignment of records.

The format and manner I wish to have my EMR Data transferred is:

Option: _____ (Note: you may choose more than 1 option)

A: Data Export  B: Electronic Print  C: Assignment of Records to Another Provider

Provider Name: _____ Provider Signature: _____

I understand and acknowledge that I am responsible for any and all costs associated with this/these option(s) and that Telus will discuss options and costs as part of the termination process.

Reset Form  Print Form

# eDOCSNL Program Termination/Withdrawal Notification

## Step 3: Provider Termination Information:

Complete the table below with the terminating provider's information

Anticipated End Date: _____

Last Name: First Name: Middle Name/Initial:

Clinic Name:

License Number: Provider Mnemonic:

MCP Billing: Email:

Main Phone: Direct Phone:

Reason for Termination:

## Step 4: Signature

SIGNED at the City/Town of in the Province of Newfoundland and Labrador this

day of , 20

Provider Name: Provider Signature:

## Step 5: Email, fax or mail completed signed form to:

**eDOCSNL**
c/o NL Centre for Health Information
70 O'Leary Avenue
St. John's, NL A1B 2C7
Email: info@edocsnl.ca Fax: 709-752-6529

*Personal information collected on this form is collected under the Newfoundland and Labrador Access to Information and Protection of Privacy Act and will only be used for the administration of eDOCSNL. Inquiries about the use and protection of this personal information should be directed to the ATIPPA Coordinator at NL Centre for Health*

Reset Form Print Form