

Securing Bring Your Own Application AI Scribes for Northern Health (Step-by-step)

Note: Vendors are continuously changing their applications to incorporate new features and functionality. This often results in changes to their user interfaces. The images used in this document are current as of **February 26, 2026**.

- **Audience:** Physicians and clinical staff using Bring Your Own Application (BYOA) AI scribes in NH clinical settings.
- **Goal:** Minimize privacy and access risks without compromising clinical functionality. NH provided EMR/EHR (MOIS, Cerner) are the system of record.
- **Supporting Resources:** BC Scribe Self Pay Program: [Important Resources](#)

Mutuo AutoScribe

AutoScribe is a web-based digital assistant that transcribes clinician–patient dialogue and generates clinical notes for EMR use.

Support and escalation

Support for this application is entirely provided by the vendor. Please review the support links below.

- Vendor Site: [AutoScribe | Streamline Clinical Documentation with AI](#)
- Vendor Help: [AutoScribe Help Centre](#)
- Provincial Toolkit: [How-To Document list_.docx | Powered by Box](#)

1. Canadian residency / in-Canada processing

Data for this application resides in Canada. There is no option to change this in the application.

2. Data retention and deletion

This application does not allow the user to determine data retention limits. It does allow the user to delete documentation created and stored within the application.

3. Auto logout / session management

Autoscribe can remember you for up to 12 hours. As stated this is not recommended for shared computers.



Please login to see this page.

Username

Password

Remember me for 12 Hours

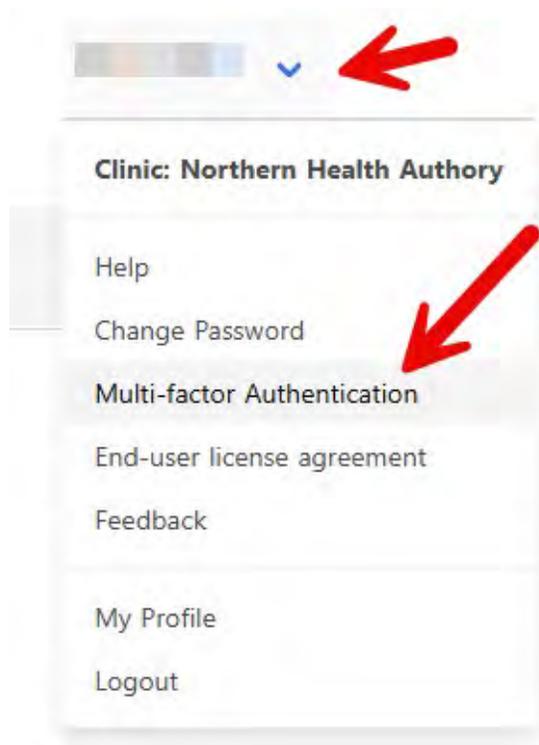
Not recommended for shared work stations.

Login

[Lost password?](#)

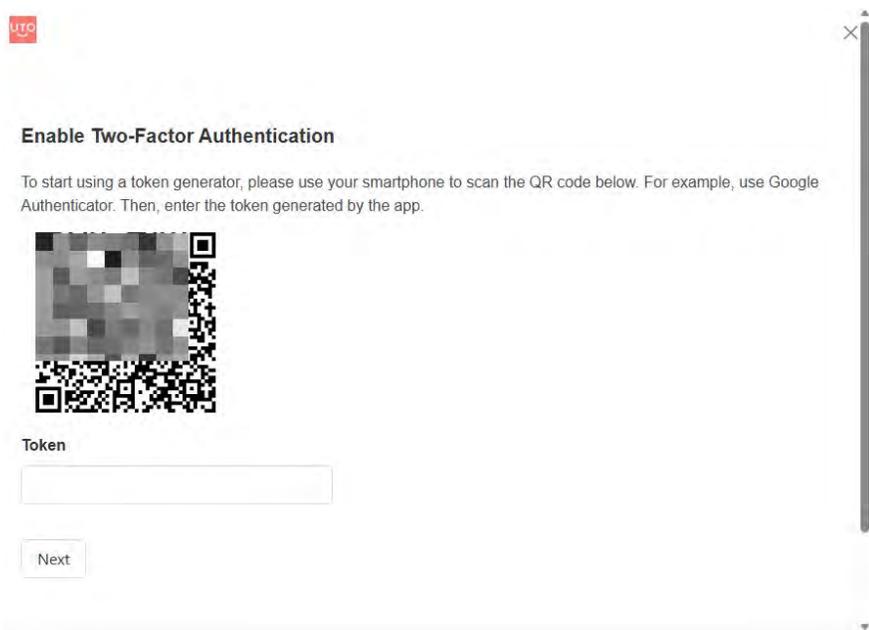
4. Multi-factor authentication (MFA) and access restrictions

To ensure the highest level of security for patient information. It is strongly recommended that you enable MFA. This can be done in AutoScribe through the settings button on the top right corner of the screen.

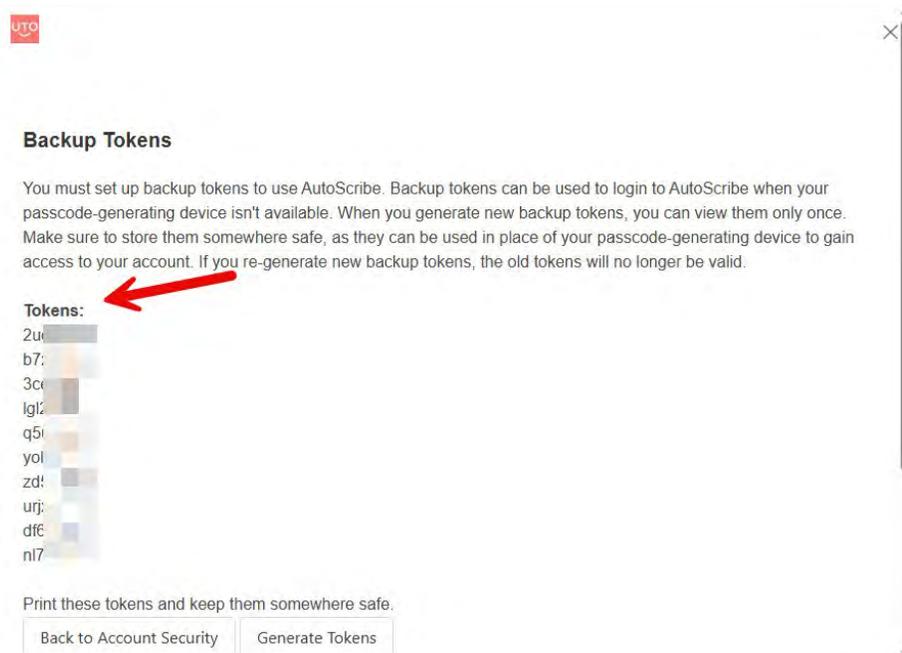


Enabling MFA will start the workflow:

1. Open the camera application on your phone to scan the QR code.
2. The setup process on your phone will vary by device and the authenticator application



3. As part of the setup, you will be provided a series of “backup tokens”. These are provided as a backup in case your authenticator isn’t available. These can be pasted into the Token field as an alternative way of authenticating. Store these in a secure location.



4. When you are logging in the application, will ask you to provide your username and password, followed by a request to enter the token. This token should be provided by applications such as Google Authenticator that was used on MFA setup.

Please enter the tokens generated by your token generator.

Token



Don't ask again on this device for 12 hours

As a last resort, you can use a backup token:

5. Transcription accuracy and clinician validation

Review and edit the generated note before submitting it to the EMR. Remove any non-medically relevant sections before saving.

6. Patient notice and consent workflow

Only begin recording with expressed consent of the patient. Use the NH Automated Transcription Notice and obtain verbal consent at the start of each encounter. If the patient declines, do not use the tool for that encounter. The application has removed the ability to set consent preference.

The NH clinician is expected to present an NH Automated Transcription Notice to the NH client to further explain the use of 'automated transcription' for NH service improvements, and to obtain verbal consent from the client (per [College](#) and [CMPA](#) guidelines).

Automated Transcription Notice

Northern Health (NH) has adopted use of automated transcription technology to improve the delivery of health care for our clients.

The technology uses a secured and approved artificial intelligence technology to transcribe real-time conversation between an NH clinician and client during a health care session.

The medically relevant words spoken during the health care session are automatically drafted into clinical documentation, which the NH clinician reviews and confirms in advance of manually copying into the client health record.

Historically, the medically relevant content from a verbal conversation between a clinician and their client during a health care session has always been entered manually into the client's health record by the clinician.

The use of automated transcription is a modern update to this practice, to further support NH improvements to health care services.

How it works

Automated transcription uses an artificial intelligence (AI) tool called an AI scribe to assist NH clinicians with clinical documentation.

This technology translates our verbal conversation during a health care session into written words and generates a written summary. This allows us to focus more on you instead of taking notes.

The summary is used to create clinical documentation, and only medically relevant content is retained.

The documentation is reviewed and finalized by an NH clinician before adding it to your medical record. The technology does not make medical decisions—it only drafts notes.

The automated transcription solutions used at NH are subject to compliance reviews, to ensure your health information is protected as required by law.

All temporary transcription content is deleted once the final clinical documentation is saved.

If you have any questions about how it works, please ask your provider.

If you have questions about how your personal information is being managed, please contact the NH Information Privacy Office at privacy@northernhealth.ca.

7. EMR transfer and post-transfer deletion

Generate the note, review/edit, then transfer into the EMR using your local workflow (copy/paste or supported integration if configured). Confirm the note is saved in the EMR, then delete the encounter/note from the scribe app if your plan provides a deletion function.

Encounters											
										Active	Submitted
Date	Patient Name	Birth Date	Clinic	Clinician	Plan Level	End Date	Patient Handout	Date Last Emailed	Date Last Printed	Actions	
Feb 26 2026 11:54 AM	Patient 001	Jan 01 1980	Northern Health Authority			Feb 26 2026 11:54 AM	Yes				

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8. NH recommended usage checklist

- Use the shortest-retention option available for NH encounters.
- Enable MFA and do not share accounts.
- Obtain patient consent before recording/transcribing.
- Clinician review is mandatory before EMR submission.
- Transfer to EMR promptly; delete residual data in the scribe tool where possible.
- Log out at the end of the session.