Authorization for Proxy Access to Patient's Health Information via my health care

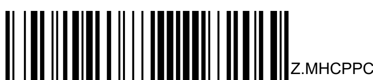
☐ Authorize Proxy Access (complete sections A and B) ☐ Revoke Proxy Access (complete section C)

INFORMED CONSENT: PATIENT

- I acknowledge that the above-named individual is my designated **my health care** proxy.
- I authorize the hospital(s) to allow the above-mentioned individual to access my personal health information available on **my health care**.
- I authorize this individual to have access to my personal health information only through **my health care**. This consent does not authorize the release of my health record to my designated proxy by other methods or in other forms.
- I understand that once information has been disclosed, it potentially may be re-disclosed by my proxy and the disclosed information may or may not be covered by privacy protections.
- Participation in **my health care** and designating a proxy is completely voluntary.
- I understand that access to **my health care** is provided by the hospital(s) as a convenience to its patients and that the hospital(s) has the right to deactivate access to **my health care** at any time for any reason.
- I understand that I am not required to designate a proxy and I am not required to provide this authorization.
- I understand that **my health care** treatment or other services will not be conditional on whether I provide this authorization.
- I understand that if I do not provide authorization, the hospital(s) is not permitted to provide the above-named individual access to **my health care**.
- I understand that I am able to revoke this authorization at any time by providing a written request for revocation to my **health care** Support team.
- I understand that if I revoke this authorization, my designated proxy's access to **my health care** will be terminated.
- I understand my revocation is not applied retroactively and will not affect any disclosures that were made prior to processing the revocation request.

MY HEALTH CARE USER AGREEMENT: PROXY

- I understand that **my health care** is a secure, online patient portal containing confidential health information.
- I understand that if another individual receives the logon ID and password, he/she may be able to view this patient's personal health information.
- I agree that it is my responsibility to select a confidential password and keep it secure.
- I agree that I will not share the logon ID and password to access this patient's portal account.
- I agree that I will change the password if I believe that it may have been compromised in any way.
- I agree that it is my responsibility to ensure that the device used for accessing **my health care** has an up-to-date operating system and adequate protection from online threats.
- I will not access **my health care** using a public computer where I cannot be sure of the device security.
- I understand that **my health care** contains selected, limited personal health information from the patient's health record and that **my health care** does not reflect the complete contents of the health record.
- Additional information that is not available within **my health care** shall be requested from the Health Records department from the applicable hospital(s) with a valid ***Authorization for Release of Personal Health Information*** form.
- I understand that my activities within **my health care** may be audited by the hospital(s).



PROXY CONSENT AND ACCESS FORM TO PATIENT PORTAL

my health care is a secure, online portal that connects a patient to portions of their health record at Collingwood General and Marine Hospital (CGMH), Georgian Bay General Hospital (GBGH), Headwaters Healthcare Centre (Headwaters) and Royal Victoria Regional Health Centre (RVH). If you would like to assign a proxy to have access to this portal on your behalf, please read this form carefully and complete the appropriate fields below. **Please note that we are unable to add more than one e-mail address per patient.**

PART A: PATIENT INFORMATION *(all sections required – please print clearly)*

Patient Name: ____
Last Name First Name Initial

Address: ____
Street Address City Province Postal Code

Medical Record Number: _______________________ Date of Birth: ______________________

Phone Number: ______________________________ Email Address: _________________________

PART B: PROXY INFORMATION *(all sections required – please print clearly)* to be completed by the patient or substitute decision-maker

Proxy Name: ____
Last Name First Name Initial

Relationship to Patient: ____

Address: ____
Street Address City Province Postal Code

Phone Number: _________________________ Email Address: _________________________

By signing below, I acknowledge that I have read and understand this document and I further acknowledge that I will read the User Agreement available at the time of online activation.

Signature of Patient or SDM: ___________________Date: ___________________
(DD/MM/YYYY)

Signature of Proxy: __________________________Date: ___________________
(DD/MM/YYYY)

Signature of Witness: _________________________Date: ___________________
(DD/MM/YYYY)

For witnesses that are not Hospital staff: The witness signature must be a neutral third party, who does not benefit from signing this legal document. The witness must be capable individual who is 16 years or older and must be present and actually see the patient sign the document.

PART C: REVOKE PROXY ACCESS *(all sections required – please print clearly)* to be completed by the patient or substitute decision-maker

I am requesting to revoke the above-named proxy from being able to access my health information via **my health care**.

Signature of Patient or SDM: ___________________ Date: ___________________