

# MY CONNECTED CARE - PATIENT PORTAL

# **Authorized Representative Form**

Waterloo Regional Health Network (WRHN) will maintain the authorized representative's access to the patient's health information based on the information provided in this form.

It is the responsibility of the patient and/or the patient's legally authorized representative to inform the hospital of any future changes to this information.

This form is to be completed by the authorized representative, with consent from the patient. The authorized representative is required to provide government-issued identification upon submission of this form.

## Important Information about My Connected Care Authorized Representatives:

- Authorized representative accounts will be granted to persons that are 16 years old and older as per the *Health Care Consent Act's* substitute decision-maker requirements.
- Access to a patient's health information by an authorized representative is automatically removed when a patient turns 12, and again when the patient turns 16. At these respective ages, allowing authorized representative access is optional.
- Patients 12 years old and older can choose to remove an authorized representative's access to their health information at any point in time. It is the responsibility of the patient to contact the 24/7 My Connected Care support line at 1-855-455-2717 to remove an authorized representative's access.

# PART 1 - Patient Information Last Name First Name Date of Birth (YYYY-MM-DD) Sex Gender Address Health Card Number Version Code WRHN Medical Record Number (if known) City Province Postal Code

PART 2 - Authorized Repres Last Name	entative #1 Inform	ation (your info	ormation)	
Date of Birth (YYYY-MM-DD)	Sex		Gender	
Address	Health Card Number	er	Version Code	
City	Province		Postal Code	
Phone Number	E-mail (		required for account)	
*only if applicable *if there are more than 2 authorized Last Name	d representatives, plea	se use the back o	f this form to provide their information	
Date of Birth (YYYY-MM-DD)	Sex		Gender	
Address	Health Card Number	er	Version Code	
City	Province			
	FIOVINCE		Postal Code	
			Postal Code	

PART 3 - Patient & Authorized Representative(s) Relationship Information
Please select one situation from Category A through C that best describes your authorized capacity to act on behalf of the patient identified in Part 1.

Category A:	Select the most appropriate for Category A:			
The patient is 12 years old or older and is able to consent themselves.	<ul> <li>I am the parent or legal guardian of the patient who is</li> <li>12-15 years old</li> </ul>			
	The patient is 16 years or older			
Category B:	Select the most appropriate for Category B:			
The patient is under the age of 12 years old.	<ul> <li>I am the parent or legal guardian of the child (age 0-11) with whom the child primarily resides</li> </ul>			
	<ul> <li>I am a legal guardian of the child (age 0-11) under a court order or legal agreement (Please provide a copy of the legal agreement with this form)</li> </ul>			
	◯ I am a Litigation Guardian			
Category C:	Select the most appropriate for Category C:			
The patient is an incapable person (as defined in the <i>Health Care Consent</i>	<ul> <li>Legal guardian of the patient (Please provide a copy of the legal agreement with this form)</li> </ul>			
Act) who is not able to exercise their own health information rights.	<ul> <li>Power of Attorney (POA) for Personal Care (Please provide a copy of the POA Documentation with this form)</li> </ul>			
By signing below, I consent to grant access understand that this authorized representation from Waterloo Regional Health Network the authorized representative(s) account at an authorized representative(s) account at an authorized representative access to a old) are exempt from a patient signature.  2. For an incapable person (aged 12 years representative and are also exempt from a documentation to validate the legal authorized.	ative(s) will have electronic access to a grough a My Connected Care account by time.  My Connected Care account on behave and older), the access may be granted a patient signature. Our organization research.	my personal health information (PHI)  I understand that I can remove the  alf of their child (less than 12 years  ed to the patient's legally authorized		
Patient Name F	Patient Signature	Date Signed (YYYY-MM-DD)		
	ehalf of the patient identified in Part 1 Representative's Signature	Date Signed (YYYY-MM-DD)		
Representative's Name	Representative's Signature	Date Signed (YYYY-MM-DD)		