island health

REQUEST ACCESS TO SOMEONE ELSE'S MYHEALTH ACCOUNT

PART 1 – Requestor Information *(your own information)*

Last Name	First Name		
Mailing Address	City	Province	Postal Code
Phone Number	Email Address (used for your MyHealth account invitation)		

PART 2 – Patient Information *(information about the patient whose MyHealth account you are requesting access to)*

Last Name	First Name	Middle Name(s)		
Former Name(s)	Date of Birth (YYYY-MMM-DD)	Personal Health Number (Care Card Number)		
Mailing Address	City	Province	Postal Code	Email Address

PART 3 – Requestor/Patient Relationship Information

Select **one** situation from Category A through C below that best describes in what capacity you are authorized to act on behalf of the person identified in Part 2.

A. The patient is 12 years old or older who is able to consent themselves	Select the most appropriate relationship: ◯ The patient is a capable adolescent aged 12-18 years ** **PLEASE NOTE:** You must reapply for 12-18 year old proxy access annually ** ◯ The patient is age 19 years or older **Proceed to Part 4**
B. The patient is under the age of 12 years	Select the most appropriate relationship: ◯ I am the legal guardian of the child (age 0-11 years) identified in Part 2 with whom the child primarily resides ◯ I am a legal guardian of the child under a court order or legal agreement **(provide a copy of the legal agreementwith this form)** ◯ I am a Litigation Guardian ◯ Other (describe):_____ **Complete Request Purpose below and then Proceed to Part 5**
C. The patient is an incapable person 12 years old or older who is not able to exercise their own health information rights	Select the most appropriate relationship: ◯ I am a legal guardian of a child (age 12-18 years) identified in Part 2 who is incapable of exercising their own Health Information rights, as determined by a qualified Health Care Practitioner ◯ I am a Committee of Person for an incapable adult age 19 years or older ◯ I am a Representative under the Representation Agreement Act for an incapable adult over the age of 19 years ◯ Other (describe):_____ **Complete Request Purpose below and then Proceed to Part 5. (provide a copy of the agreement with this form)**
Request Purpose	***Describe the purpose of why you are requesting access to a child or incapable adult's MyHealth account:***

PART 4 – Patient Consent *(age 12 years or older)*

I consent to grant access to my MyHealth account to the individual identified in Part 1 (Requestor Information) of this form. I understand that in the future, additional information will be available in MyHealth, and if I wish to revoke my consent I must submit the Request Proxy Removal form to Island Health by emailing MyHealth@IslandHealth.ca. If I am providing my consent as a mature minor (age 12 – 18), I understand my consent is valid for one year from date signed and is automatically revoked when I reach the age of 19.

Patient Name (print)	Patient Signature	Date Signed (YYYY-MMM-DD)

PART 5 – Requestor Attestation

I attest that I have the legal authority to act on behalf of the patient identified in Part 2 and the information I have provided is truthful and accurate.

Requestor Name (print)	Requestor Signature	Date Signed (YYYY-MMM-DD)

Send your completed form to Island Health:

- Email: MyHealth@islandhealth.ca
- In person at any Island Health Hospital Main Admitting Desk (route to VGH Health Records Department)
- Mail: Health Records Department, Victoria General Hospital, 1 Hospital Way, Victoria BC, V8Z 6R5

For more information on MyHealth visit www.islandhealth.ca/myhealth

The information provided in this form is collected under Section 26(c) of the Freedom of Information & Protection of Privacy Act.