



# REQUEST ACCESS TO SOMEONE ELSE'S MYHEALTH ACCOUNT

PART 1 – Requestor Information <i>(your own information)</i>			
Last Name		First Name	
Mailing Address		City	Province
		Postal Code	
Phone Number		Email Address (used for your MyHealth account invitation)	

PART 2 – Patient Information <i>(information about the patient whose MyHealth account you are requesting access to)</i>			
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	

PART 3 – Requestor/Patient Relationship Information	
Select <b>one</b> 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: <input type="radio"/> The patient is a capable adolescent aged 12-18 years <input type="radio"/> The patient is age 19 years or older <b>Proceed to Part 4</b>
B. The patient is under the age of 12 years	Select the most appropriate relationship: <input type="radio"/> I am the legal guardian of the child (age 0-11 years) identified in Part 2 with whom the child primarily resides <input type="radio"/> I am a legal guardian of the child under a court order or legal agreement (provide a copy of the legal agreement with this form) <input type="radio"/> I am a Litigation Guardian <input type="radio"/> Other (describe): _____ <b>Complete Request Purpose below and then Proceed to Part 5</b>
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: <input type="radio"/> 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 <input type="radio"/> I am a Committee of Person for an incapable adult age 19 years or older <input type="radio"/> I am a Representative under the Representation Agreement Act for an incapable adult over the age of 19 years <input type="radio"/> Other (describe): _____ <b>Complete Request Purpose below and then Proceed to Part 5</b>
Request Purpose	<b>Describe the purpose of why you are requesting access to a child or incapable adult's MyHealth account:</b>  

PART 4 – Patient Consent <i>(age 12 years or older)</i>		
I consent to grant access to my MyHealth account to the individual identified in Part 1 (Requestor Information) of this form. I understand this consent is valid until I turn 19 years of age and/or I request the access be removed by completing and submitting the <i>Request Proxy Removal</i> form to Island Health. 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 <i>Request Proxy Removal</i> form to Island Health.		
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@viha.ca](mailto:MyHealth@viha.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, V9Z 6R5