WRHN
Waterloo Regional Health Network

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 Representative #1 Information *(your information)*

Last Name

First Name

Date of Birth (YYYY-MM-DD)

Sex

Gender

Address

Health Card Number

Version Code

City

Province

Postal Code

Phone Number

E-mail *(required for account)*

Authorized Representative #2 Information *(your information)*

**only if applicable*

**if there are more than 2 authorized representatives, please use the back of this form to provide their information*

Last Name

First Name

Date of Birth (YYYY-MM-DD)

Sex

Gender

Address

Health Card Number

Version Code

City

Province

Postal Code

Phone Number

E-mail *(required for account)*

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:

The patient is 12 years old or older and is able to consent themselves.

Select the most appropriate for Category A:

- ◯ I am the parent or legal guardian of the patient who is 12-15 years old
- ◯ The patient is 16 years or older

Category B:

The patient is under the age of 12 years old.

Select the most appropriate for Category B:

- ◯ I am the parent or legal guardian of the child (age 0-11) with whom the child primarily resides
- ◯ 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)
- ◯ I am a Litigation Guardian

Category C:

The patient is an incapable person (as defined in the *Health Care Consent Act*) who is not able to exercise their own health information rights.

Select the most appropriate for Category C:

- ◯ Legal guardian of the patient (Please provide a copy of the legal agreement with this form)
- ◯ Power of Attorney (POA) for Personal Care (Please provide a copy of the POA Documentation with this form)

PART 4 - Patient Consent

By signing below, I consent to grant access to the authorized representative(s) identified in Part 2 of this form. I understand that this authorized representative(s) will have electronic access to my personal health information (PHI) from Waterloo Regional Health Network through a My Connected Care account. I understand that I can remove the authorized representative(s) account at any time.

Please note:

1. Parents who are requesting access to a My Connected Care account on behalf of their child (less than 12 years old) are exempt from a patient signature.
2. For an incapable person (aged 12 years and older), the access may be granted to the patient's legally authorized representative and are also exempt from a patient signature. Our organization may request supporting documentation to validate the legal authority.

Patient Name	Patient Signature	Date Signed (YYYY-MM-DD)

PART 5 - Authorized Representative(s) Attestation

I attest that I have the authority to act on behalf of the patient identified in Part 1 of this form and the information I have provided is truthful and accurate.

Representative's Name	Representative's Signature	Date Signed (YYYY-MM-DD)
Representative's Name	Representative's Signature	Date Signed (YYYY-MM-DD)