MY Humber Health Proxy Consent and Access Form

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MY Humber Health is a secure, online patient portal that connects a patient to portions of their health record at Humber River Hospital. 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.**

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

Medical Record Number:_____
Account Number: _____

Patient Name: _____ Date of Birth: _____
LAST NAME *FIRST NAME* *(DD/MM/YYYY)*

Address: _____
STREET ADDRESS *CITY* *PROVINCE* *POSTAL CODE*

Phone Number: (_____)_____-_____

The following section should be completed by the patient or substitute decision maker (SDM) authorizing another individual to access the patient's personal health information available on MY Humber Health.

PROXY INFORMATION *(all sections required – please print clearly)*

Proxy Name: _____ Relationship to Patient: _____
LAST NAME *FIRST NAME*

Address: _____
STREET ADDRESS *CITY* *PROVINCE* *POSTAL CODE*

E-mail: _____ Phone Number: _____

INFORMED CONSENT – PATIENT

- I acknowledge that the above named individual is my designated MY Humber Health proxy.
- I authorize HRH to allow the above mentioned individual to access my personal health information available on My Humber Health.
- I authorize this individual to have access to my personal health information only through MY Humber Health. 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 Humber Health and designating a proxy is completely voluntary.
- I understand that access to MY Humber Health is provided by HRH as a convenience to its patients and that HRH has the right to deactivate access to MY Humber Health 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, HRH is not permitted to provide the above named individual access to MY Humber Health.
- I understand that I am able to revoke this authorization at any time by providing a written request for revocation to the Health Information Services department (3rd floor of the hospital).
- I understand that if I revoke this authorization, my designated proxy's access to MY Humber Health record 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.

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MY HUMBER HEALTH USER AGREEMENT – PROXY

- I understand that MY Humber Health 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 Humber Health has an up-to-date operating system and adequate protection from online threats.
- I will not access MY Humber Health using a public computer where I cannot be sure of the device security.
- I understand that MY Humber Health contains selected, limited personal health information from the patient's health record and that MY Humber Health does not reflect the complete contents of the health record.
- I understand that a paper copy of the patient's health record must be requested from the Health Information Services department (3rd floor of the hospital) with a valid ***Authorization for Release of Personal Health Information*** form.
- I understand that my activities within MY Humber Health may be audited by Humber River Hospital.

By signing below, I acknowledge that I have read and understand this document and I further acknowledge that I will read the Terms and Conditions 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)

Print Name of Witness: _____

Relationship to Patient: _____

For witnesses that are not HRH 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.

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