I have my own MyHealthPortal account

↓ Yes

I am the parent/legal guardian of a **minor child (0–11)** and would like to have access to their MyHealthPortal Record.

OR

I am the parent/legal guardian of a **minor (12–18)** or caregiver of an adult that is incapable of exercising their information rights due to permanent mental disability.

↓ Yes

- Complete the **Authorization For Access To MyHealthPortal Account for Minor 0-11, Incapable Minor or Incapable Adult**.
- If you have a straightforward relationship (same address as child, or you are their Person to Notify or Next of Kin), you can mail the completed form to:

  MyHealth Portal Staff
  2355 Acland Road
  Kelowna, BC, V1X 7X9

- Or: Take the form and supporting documentation, if required, to your local Health Records department for processing
- If the request is urgent, please contact our support team for further instructions. Do not email this completed form.

↓ No

How to get a MyHealthPortal account

- You must have your email address added to your electronic medical record to enrol. You can do this by calling our MyHealthPortal Support line, or by presenting in person at Registration at an IH facility.
- Go to www.interiorhealth.ca/myhealthportal and click the Request to Enrol button.
- Follow the instructions to complete your enrolment.

MyHealthPORTAL
Interior Health

825037 Jan 4-22

Interior Health

Parental Access to Minors 0–11 Years of Age

and Parental/Caregiver Access for Minors 12–18 OR Adults that are Incapable of Exercising their Information Rights

For further information contact MyHealthPortal Support at 1-844-870-4756 or email MyHealthPortal@interiorhealth.ca

Interior Health

AUTHORIZATION FOR ACCESS TO MYHEALTHPORTAL ACCOUNT FOR MINOR 0 – 11, INCAPABLE MINOR, OR INCAPABLE ADULT

Patient Name *(last)* _____

(first) _____

DOB *(dd/mm/yyyy)* _____

PHN _____ MRN _____

Account / Visit # _____

IH USE ONLY

Personal Information Contained on this form is collected under The Freedom of Information and Protection of Privacy Act and will be used only for the purpose of responding to your request.

☑ Please check the appropriate box below to indicate what authority you have to act on behalf of the client.
☑ You must be the highest ranking individual shown on the list and proof of status will be required.
☑ Please note, if a dispute exists (e.g. lack of clarity regarding status) the access will be denied. Applicants may appeal the decision with the Office of the Information & Privacy Commissioner

Part 1. CLIENT INFORMATION (please print clearly)

Last Name of Client _____ First Name of Client _____

Mailing Address _____

City _____ Province _____ Country _____ Postal Code _____

Phone (_____) _____ DOB *(dd/mm/yyyy)* _____ PHN _____

Part 2. PERSON RECEIVING ACCESS (Must have own MyHealthPortal Account)

Name of person receiving the access (Last, First): _____

Mailing Address _____

City _____ Province _____ Country _____ Postal Code _____

Phone (_____) _____ PHN _____ Email _____

Part 3. AUTHORIZATION ON BEHALF OF THE CLIENT (If Client is under the age of majority and not actively involved in decisions about health care or incapable of exercising information rights.)

- Please check the appropriate box below in either Part 3 a or 3 b, to indicate what authority you have to act on behalf of the Client.
- You must be the highest ranking individual shown on the list and proof of status must be provided.
- Complete all fields in 3c, date and sign.

3a) Authorization on behalf of a client who is under the age of 19

☐ Parent with whom the child primarily resides
☐ Parent with whom the child does not reside but has guardianship
☐ Legal Guardian granted by Court Order or Separation Agreement

3b) Authorization on behalf of adult client incapable of exercising their information rights:

☐ Personal Representative (Committee of Person)
☐ Personal Representative (Committee of Estate)
☐ Litigation Guardian (see Supreme Court Civil Rules)
☐ Representative with legal authority (Representation Agreement)
☐ Spouse (including common law and/or same sex partner residing with the client in a marriage like relationship)
☐ Adult Child of Client
☐ Parent of Client
☐ Adult Brother or Sister of Client
☐ Other adult relation of Client other than by marriage *(Specify):* _____
☐ Other adult immediately related to Client by marriage *(Specify):* _____

3c) By signing below, I declare that I have legal authority to act on behalf of the Client and I hereby authorize the Hospital/Facilty to provide access to the MyHealthPortal record request to the person name above in Part 2 "Person Receiving Access" for the sole purpose of acting in the Client's best interest.

☐ I have indicated my relationship to the Client above; and
☐ If applicable, I have attached documentation to show my status as legal representative or guardian (e.g. copy of Will, court order, legal agreement, or other documentation).
☐ Reason for Request: _____

Date (dd/mm/yyyy)	Full Name	Signature

Permanent part of the health record

HEALTH RECORD USE ONLY Supporting Documentation Reviewed & Authorization Validated (provide specific details):

Date (dd/mm/yyyy)	Time (24 hour)	Staff Initial	Designation
/ /			