

connect2care Access Request Form

Holland Bloorview's connect2care Health Portal is a secure, online tool that connects you to portions of your child's electronic health record. To request access to connect2care, please read this form carefully and complete the appropriate fields below.

The following age ranges govern use of connect2care:

- **Between the ages of 0-15:** The parent or legal guardian can be granted full access to a client's connect2care record by proxy by filling out the form below, unless the client (with capacity) advises Holland Bloorview that he/she doesn't want a parent or legal guardian to have access to their connect2care record. **The parent or legal guardian must complete Sections A, B, and D.**
- **At age 16 or older:** The parent or legal guardian will only have access to a client's connect2care record if the client gives permission by proxy by filling out the form below. **Section C (Proxy Designation) must be completed.**

connect2care access will not affect your legal right to access your child's health record by other means. To request a paper copy of your record, contact the Health Information Management Department.

SECTION A

Client Information: (All sections required – please print clearly)

Name (last, first, middle initial) _____
Medical Record Number (MRN) See Enrollment Officer _____
Date of Birth _____
Street Address _____ City _____
Province _____ Postal Code _____
Phone Number _____
Will the client be accessing connect2care? If so, client's email is required.
Client's email _____

Are any siblings accessing services at Holland Bloorview? Yes / No _____

****Please note a separate access form is required for each child****

SECTION B

Parent/Guardian Information: For children 16 and under (All sections required – please print clearly)

Name (last, first, middle initial) _____
Relationship to client _____ Date of Birth _____
Street Address _____ City _____
Province _____ Postal Code _____
Phone Number _____
Email Address _____

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SECTION C

Proxy Designation: *(To be filled out by client ONLY if granting proxy access)*

This section authorizes Holland Bloorview Kids Rehabilitation Hospital to release your personal health information to another individual such as a parent(s) or legal guardian (proxy). Proxy access can only be granted to your parent(s) or legal guardian. Please read carefully. This section should be completed by the client.

Client Information: (All sections required – please print clearly)

Name *(last, first, middle initial)* _____

Medical Record Number (MRN) *See Enrollment Officer* _____

Date of Birth _____

Street Address _____ City _____

Province _____ Postal Code _____

Will the client be accessing connect2care? If so, client's email is required.

Client's email _____ Phone Number _____

I am requesting that _____ *(insert first and last name of proxy)* receive access to my health information available in Holland Bloorview's connect2care portal.

My Proxy's Information:

Name *(last, first, middle initial)* _____

Relationship to client _____ Date of Birth _____

Street Address _____ City _____

Province _____ Postal Code _____

Email Address _____ Phone Number _____

This person is my designated connect2care proxy *(Place a checkmark in each box)*

- ☐ I authorize Holland Bloorview to release the health information contained in my connect2care record to this connect2care proxy
- ☐ I authorize release of this information only through my connect2care record. This form does not authorize release of my medical record to my designated proxy by other methods or in other forms.
- ☐ I understand that once information has been disclosed, it potentially may be e-disclosed by the proxy and the disclosed information may or may not be covered by privacy protections.

Participation in connect2care and designating a connect2care proxy is completely voluntary. I understand that I am not required to designate a connect2care proxy and I am not required to provide this authorization. I also understand that my health care treatment or other services will not be conditional on whether I provide this authorization. However, I also understand that if I do not provide authorization, Holland Bloorview is not permitted to provide access to my connect2care record to my designated proxy.

I may revoke this authorization at any time by providing a written request for revocation to Holland Bloorview's Health Information Management or completing the connect2care Deactivation Request Form. I understand that if I revoke this authorization, my designated proxy's access to my connect2care record will be ended. I also understand my revocation will not affect any disclosures that were made prior to processing the revocation request.

NOTE: You may de-activate your proxy's access at any time by completing the connect2care Deactivation Request Form.

Signature of Client

Date



SECTION D

connect2care User Agreement

The Portal is an internet-based system designed to give clients or another person chosen by the client (a "proxy"), the opportunity to securely (a) view portions of their health record and appointment schedule, and (b) communicate with authorized healthcare practitioners regarding their care. The Portal uses encryption and other security measures designed to keep unauthorized persons from reading communications, information, or attachments. Other security measures protect information maintained within the connect2care site. The website for Holland Bloorview's connect2care has a trusted site certificate, which is viewable from your browser's task bar. (You can learn more about trusted sites by going to Microsoft.com and searching "when to trust a website"). Additional details and security measures are included in the full user agreement which can be found under "Terms and Conditions" on the Portal homepage.

- ☐ I understand that connect2care is intended as a secure online source of confidential medical information and that if another individual receives my connect2care ID and password, he/she may be able to view my 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 my connect2care ID and password. I will change my password if I believe it may have been compromised in any way.
- ☐ In the event that I wish to provide access to connect2care to another individual, I will provide such individual with proxy access to my connect2care record.
- ☐ I agree that it is my responsibility to ensure that the device used for accessing connect2care has a current operating system (Windows, Mac) and an updated and current internet browser (e.g. Google Chrome, Firefox). I will not access connect2care using a public computer where I cannot be sure of the device's security.
- ☐ I understand that connect2care contains selected, limited medical information from my child's health record and that connect2care does not reflect the complete contents of the health record. I also understand that a paper copy of my child's health record may be requested from Holland Bloorview's Health Information Management Department.
- ☐ I understand that my activities within connect2care may be tracked by computer audit and that messages I send through connect2care will become part of the medical record.
- ☐ I understand that connect2care access will be suspended after 24 months of inactivity. It can be reopened by visiting Holland Bloorview's Health Information Management Department or onsite Enrollment Station.
- ☐ I understand that access to connect2care is provided by Holland Bloorview as a convenience to its clients and families and that Holland Bloorview has the right to deactivate access to connect2care at any time for any reason. In the unfortunate event of a client's death, connect2care access will be deactivated.
- ☐ I understand that use of connect2care is voluntary and I am not required to use connect2care or to authorize a connect2care proxy.
- ☐ Where applicable, I agree to designate the person named above as a connect2care Proxy, thereby allowing them access to my personal health information.
- ☐ I agree that Holland Bloorview is not responsible for any errors contained in the information I provided on this form, or any inappropriate release of information caused by those errors.
- ☐ I agree that Holland Bloorview may contact me electronically with information about connect2care or to request feedback related to my experience using connect2care.
- ☐ I agree to notify Holland Bloorview immediately of any unauthorized use of your Logon ID and/or Password or any other breach of security, and to ensure that I exit from my account at the end of each session.
- ☐ I understand that Holland Bloorview may use information about usage of the connect2care Portal for the purposes of quality improvement.
- ☐ **I will not use connect2care to communicate or treat medical emergencies. If I have a medical emergency, I will call 9-1-1 immediately or go to the nearest hospital emergency department. Under no circumstances should I attempt self-treatment based on anything I've seen or read on connect2care.**
- ☐ I understand that connect2care does not create physician-client relationships. The presentation of information in connect2care does not establish a physician-client relationship between me and Holland Bloorview or any of its physicians or other qualified health care providers.
- ☐ I understand that a client 16 years or over with capacity has the right to sever (deactivate) the Portal account access of a parent or guardian, in accordance with privacy laws. I understand that Holland Bloorview will not automatically deactivate proxy access for a parent or guardian unless the client requests that this access will be severed.

I acknowledge that I have read and understand this connect2care Access Request Form and this User Agreement.

Client Name _____ **Date** _____

Name of Parent/Guardian/Proxy _____ **Date** _____



Privacy & Identification Disclaimer

For your security and to protect your personal information, please do not email, upload, or attach copies of any government-issued identification with your registration form. The list of accepted ID types is provided for reference; however, this does not mean that ID copies should be submitted electronically with the registration form. The enrollment officer will verify your identification through a visual inspection only, either in person or during an arranged Zoom appointment.

LIST OF ACCEPTED FORMS OF IDENTIFICATION

Two pieces of ID is preferred. If a client/substitute decision maker has only one piece, it must be their OHIP card.

Photo Identification:

- ☐ Ontario Health Card (OHIP card)
- ☐ Driver's License
- ☐ Government Employment Card
- ☐ Age of majority Card
- ☐ Canadian Citizenship Card
- ☐ Indian Status Card
- ☐ International Student Card
- ☐ Ontario Photo Card
- ☐ Passport
- ☐ Permanent Resident Card
- ☐ Firearms Acquisition Certificate (FAC)
- ☐ Canadian National Institute for the Blind Card (CNIB)
- ☐ Student Card

Non-Photo Identification:

- ☐ Ontario Health Card (OHIP card)
- ☐ Birth Certificate
- ☐ Hospital Card
- ☐ Canadian Blood Donor Card
- ☐ Immigration Papers
- ☐ Other

- ☐ Client's OHIP card checked

Completed/account activated by : _____ Date: _____
Enrollment Officer

