

Hospital #: _____

MYCHART ADULT/ADULT ACCESS APPLICATION
(Adult Access to the Electronic Medical Record of another Adult)

Washington County Hospital & Clinics
Health Information Management, PO Box 909, Washington, IA 52353
Telephone: 319-863-3990; Fax: 319-863-3963; Email: ROI@wchc.org

Patient information (a separate form is required for each patient):

_____		_____	
Patient's full legal name		Date of birth	
_____		_____	
Complete mailing address	City	State	Zip code

1) **Individual** information:

_____		_____		_____	
Individual's full legal name		Date of birth		Mobile number	
_____		_____		_____	
Complete mailing address	City	State	Zip code		

Email address					

2) If applicable, **Individual** information:

_____		_____		_____	
Individual's full legal name		Date of birth		Mobile number	
_____		_____		_____	
Complete mailing address	City	State	Zip code		

Email address					

I am allowing the individual(s) named above to electronically view my Washington County Hospital & Clinics medical record via MyChart.

This consent is voluntary. If I cancel this consent at a later date, I must notify Health Information Management listed above. If this consent is cancelled, I understand that information may have been released prior to the cancellation, and that action would not be considered a breach of confidentiality. I also acknowledge that: 1) recipients of this information may possibly re-release the information without proper authorization, and 2) once information is disclosed it may no longer be protected by federal privacy regulations. I understand my Washington County Hospital & Clinics medical record includes information about any treatment I may have received for substance abuse, mental health, HIV-related conditions, and information about any genetic tests that may have been performed. I understand that it is not technically possible at this time to grant MyChart access that would not include these categories of information. I understand this electronic access will be in effect until revoked by the patient and ends at the time of death.

This form is not needed for the patient to be evaluated or treated. I verify the above email address/mobile number is correct and I have received permission from the individual(s) listed to receive this confidential information via this email address/mobile number. I have explained to them that this may not be a secure means to receive information. I understand MyChart access can be revoked by Washington County Hospital & Clinics at any time if not used appropriately.

_____		_____	
Patient's signature*		Date	
_____		_____	
Complete mailing address	City	State	Zip code
_____		_____	
Relationship	Witness signature		

*If not signed by the patient, list relationship, include witness signature, and legal documentation is required.

Once completed, return U.S. mail, fax, or email, as listed above.

Internal use only:
Verified and processed by: _____ Date: _____