Hosp # _____

Cass Health
MyChart Access Application
Authorization to Allow Access to the Electronic Medical Record

Patient's Full Legal Name	Telephone Number	Date of Birth	Gender
Complete mailing address/street	City	State	ZIP Code
E-mail Address			

I understand that by signing this form I am requesting access to my electronic medical record. I agree to the terms and conditions of MyChart which can be found on the MyChart Website. I understand that this access will be in effect until such time that I notify the Director of Health Information Management at the address below, in writing, to terminate this access. Access to MyChart can be revoked at any time.

Your request will be processed within 3 business days of receipt, further instructions will be sent via the U.S. mail or e-mail. I verify the above e-mail address is correct and approve receiving this confidential information (activation code) via this e-mail address. I undertand this may not be a secure means to receive information.

Signature of Patient _____ Date _____

Mail Completed Form to: Cass Health
ATTN: ROI - HIM Department
1501 E 10th St
Atlantic, IA 50022
Email Completed Form to: mychart@casshealth.org
Fax Completed Form to: 712-243-7583
Questions may be directed to: 712-250-8235

Internal use only: Verified and access entered by _____ Date _____