Hosp # _____

Iowa City Cancer Treatment Center
MyChart Adult/Adult Access Application
Adult Access to the Electronic Medical Record of an Adult Patient

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

By signing this form, I am allowing the person(s) named below to electronically view my medical record via MyChart. Please

(1) Full Legal Name of Person	Telephone Number	Date of Birth	
Complete mailing address/street	City	State	ZIP Code
E-mail Address	Relationship to patient (Optional)		

(2) Full Legal Name of Person (if applicable)	Telephone Number	Date of Birth	
Complete mailing address/street	City	State	ZIP Code
E-mail Address	Relationship to patient (Optional)		

This authorization is voluntary. If I choose to cancel this consent at a later date, I must send written notification to the Director of Health Information Management at the address below. If this consent is cancelled, I understand that information previously viewed by the above named person(s) 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. This hospital does not require completion of this form as a condition of evaluation or treatment. I understand that my medical record includes information about any treatment I may have received for substance abuse, mental health, or 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. This agreement will continue until cancelled by the patient/guardian. Access can be cancelled on-line via MyChart. I verify the above named individual(s) have given verbal permission to receive their MyChart activation code via the e-mail address listed above. I have explained to them this may not be a secure means to receive information.

Patient Signature* _____ Date _____ Relationship, if Not the Patient_____
(*If not signed by the patient, legal documentation is required.)

Witness Signature _____

Mail Completed Form to: Iowa City Cancer Treatment Center
Health Information Department: Release of Information, MyChart
3010 Northgate Drive
Iowa City, IA 52245
Email Completed Form to: consentform@icradonc.com
Fax Completed Form to: 319-354-9545
Questions may be directed to: 319-354-8777

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