

Hospital #: \_\_\_\_\_

### MYCHART CAREGIVER ACCESS APPLICATION (Pediatric)

(Parent/Guardian Access to the Electronic Medical Record of a Minor with a Developmental Disorder who lacks Decision Making Ability)

#### Myrtue Medical Center

ROI - Health Information Management Department, 1213 Garfield Ave, Harlan, IA 51537

Telephone: 712-755-4360; Fax: 712-755-2640; Email: [mychart@myrtuemedical.org](mailto:mychart@myrtuemedical.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) **Parent/Guardian** information:

\_\_\_\_\_  
Patient/Guardian's full legal name Date of birth Mobile number

\_\_\_\_\_  
Complete mailing address City State Zip code

\_\_\_\_\_  
Email address

Relationship to patient:  Parent  Guardian\*  Other\*: \_\_\_\_\_

2) If applicable, **Parent/Guardian** information:

\_\_\_\_\_  
Patient/Guardian's full legal name Date of birth Mobile number

\_\_\_\_\_  
Complete mailing address City State Zip code

\_\_\_\_\_  
Email Address

Relationship to patient:  Parent  Guardian\*  Other\*: \_\_\_\_\_

\*Legal documentation is required.

I certify that I am the parent or legal guardian of the patient listed above, confirm they have a mental health disorder, and that all information provided is correct. If I am not the parent but legal guardian, I have provided the required documentation. I hereby request access to the patient's electronic medical record. For parents, I understand this electronic access will automatically end upon the patient's 18<sup>th</sup> birthday or if the patient or provider revokes access prior to that time and ends at the time of death. For legal guardians, I understand this electronic access will automatically end after one year (or as indicated in legal documents), or upon the patient's 18<sup>th</sup> birthday unless the patient or provider revokes access prior to that time 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 approve receiving this confidential information via this email address/mobile number. I understand this may not be a secure means to receive information. I understand MyChart access can be revoked by Myrtue Medical Center at any time if not used appropriately.

\_\_\_\_\_  
1) Parent/Guardian signature Date

\_\_\_\_\_  
2) Parent/Guardian signature Date

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

Internal use only:

Verified and processed by: \_\_\_\_\_ Date: \_\_\_\_\_