Hospital #: _____

MYCHART CAREGIVER ACCESS APPLICATION (Adult)

(Adult Access to the Electronic Medical Record of an Adult with a Mental Health Disorder)

University of Iowa Health Care (UI Health Care)
Health Information Management Department, Release of Information Office, 3281 Ridgeway Dr., Coralville, IA 52241
Telephone: 319-356-2555; Fax: 319-356-3079 or 319-353-7944; Email: him-consentform@uiowa.edu

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

Relationship to patient: ____ Parent* ____ Guardian* ____ Other*: _____

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

_____ _____ _____
Individual'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 have been designed by the court or the patient, as the patient's legal representative during this period while the patient has a mental health disorder and that all information provided is correct. I hereby request access to the patient's electronic medical record. A copy of Letters of Appointment for Guardianship, or Durable Power of Attorney for Health Care documents are already on file or enclosed. I understand without one of these legal documents, my access will be denied. I acknowledge: 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 this electronic access will automatically end after one year unless the patient revokes access prior to that time and ends at the time of death. If applicable, a new application form will need to be re-submitted.

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 UI Health Care at any time if not used appropriately.

Signature: _____ **Date:** _____
(Patient or person legally authorized to consent for patient)

_____ _____
(Printed name of patient or legally authorized person signing) | (Relationship to patient or legally authorized person)

If not signed by the patient, legal documentation is required.

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

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

Revised: 5-2024