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)

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) **Parent/Guardian** information:

_____ _____ _____
Parent/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:

_____ _____ _____
Parent/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 18th 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 18th 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 UI Health Care at any time if not used appropriately.

Signature: _____ **Date:** _____
(Person legally authorized to consent for patient)

Signature: _____ **Date:** _____
(Person legally authorized to consent for patient)

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

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

Revised: 5-2024