Hospital #: _____

MYCHART ACCESS APPLICATION

(Patient Access to the Electronic Medical Record)

Veterans Memorial Hospital & Clinics
40 First St. SE, Waukon, IA 52172
Telephone: 563-568-5696; Email: MyChart@vmhospital.com

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

_____ _____
Email address | Mobile number

I understand this electronic access will be in effect until I notify Health Information Management listed above, to terminate this access 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 Veterans Memorial Hospital & Clinics 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)

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

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

Revised: 5-2024