Hospital #: _____

# MYCHART CAREGIVER ACCESS APPLICATION (Adult)

(Adult Access to the Electronic Medical Record of an Adult with a Developmental Disorder who lacks Decision Making Ability)

Washington County Hospital and Clinics
Health Information Management, PO Box 909, Washington, IA 52353
Telephone: 319-863-3990; Fax: 319-863-3963; Email: ROI@wchc.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) **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 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. 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 Washington County Hospital and Clinics at any time if not used appropriately.

_____ _____
Representative's signature** | Date

_____ _____ _____ _____
Complete mailing address | City | State | Zip code

_____ _____
Relationship | Witness signature

**If not signed by the patient, list relationship, include witness signature, and 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: 8-2022