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)

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) **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 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 Washington County Hospital and Clinics 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: _____

Revised: 8-2022