Mercycare Service Corporation

MyChart Access Application

Authorization to Allow Access to the Electronic Medical Record

Patient's Full Legal Name	Date of Birth		Male ______ Female ______ Gender
Complete Mailing Address/Street	City	State	Zip Code
Telephone Number	Email Address		Social Security Number **(last 4 digits)**

I understand that by signing this form I am requesting access to my electronic medical record. I agree to the terms and conditions of MyChart which can be found on the MyChart Website at mychart.mercycare.org. I understand that this access will be in effect until such time that I notify the Director of Health Information Management at the address below, in writing, to terminate this access. Access to MyChart can be revoked at any time.

Your request will be processed within 3 business days of receipt, further instructions will be sent to the email listed above.

____ ____________________

Patient's Signature Date

Mail Completed Form to: Mercy Medical Center
Health Information Management Department
Release of Information/MyChart
701 10th Street SE
Cedar Rapids, IA 52403

FAX Completed Form to: 319-369-4727
Questions may be directed to: 319-398-6161

Internal use only: Verified and access entered by _________________________________ Date:_______________

MRN # ______________________________