Mercycare Service Corporation

MyChart Incapacitated Patient Access Application

Adult Access to the Mercy Electronic Medical Record of an Incapacitated Patient

Please PRINT (except signature) and provide complete information in each section.

Each legal representative must have an existing MyChart account in order to access the adult's information. If you do not have an active account, we will issue a verification code to the legal representative so you can gain access.

_____ _____ Male _____ Female _____

Patient's Full Legal Name | Date of Birth | Gender

_____ _____ _____ _____

Complete Mailing Address/Street | City | State | Zip Code

_____ _____ _____

Telephone Number | Email Address | Social Security Number (last 4 digits)

By signing this form, I am attesting that the above named patient is currently mentally incapacitated, and I have been designated by the court or the patient as the patient's legal representative during this period of incapacitation. I am requesting electronic access to the patient's Mercy medical record via MyChart. A copy of the Guardianship Letters of Appointment, or Durable Power of Attorney for healthcare is enclosed. I understand without one of these legal documents enclosed, my access will be denied.

The following legal representative has a MyChart account: Y_____ N_____

_____ _____ _____ _____

Full Legal Name of Representative | Date of Birth | Telephone number | Relationship to patient (optional)

_____ _____ _____ _____

Complete mailing address | City | State | Zip code

_____ _____

Email Address | Social Security Number (last 4 digits)

Male _____ Female _____

Gender

If this consent is cancelled, I understand that information previously viewed by the above named person(s) would not be considered a breach of confidentiality. I also 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. Mercy does not require completion of this form as a condition of evaluation or treatment.

I understand that the Mercy medical record includes information about any treatment the patient may have received for substance abuse, mental health, or HIV-related conditions, and information about any genetic tests that may have been performed. I understand that it is not technically possible at this time to grant MyChart access that would not include these categories of information.

This access is in effect for **one year**, unless terminated earlier by the patient and then a new application form will need to be re-submitted if applicable. The patient may cancel this access on-line via MyChart, or by sending written notification to the Director of Health Information Management, Mercy Medical Center, 701 10th Street SE, Cedar Rapids, IA 52403.

_____ _____

Signature of applicant/legal representative | 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 #: _____