Mercycare Service Corporation
MyChart Adult/Adult Access Application
Adult Access to the Mercy Electronic Medical Record of an Adult Patient
Please PRINT complete information in each section and sign your signature.

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)** _____

By signing this form, I am allowing the person(s) named below to electronically view my Mercy medical record via My Chart.

(1) Full Legal Name of Person _____ Date of Birth _____ Telephone number _____ Relationship to patient (optional) _____

Complete mailing address _____ City _____ State _____ Zip code _____

(2) Full Legal Name of Person (if applicable) _____ Date of Birth _____ Telephone number _____ Relationship to patient (optional) _____

Complete mailing address _____ City _____ State _____ Zip code _____

This authorization is voluntary. If I choose to cancel this consent at a later date, I must send written notification to the Director of Health Information Management, Mercy Medical Center, 701 10th Street SE, Cedar Rapids, IA 52403. 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 agreement will continue until cancelled by the patient/guardian. Access can be cancelled on-line via MyChart.

Patient Signature* _____ Date _____

Complete mailing address (If same as above, so indicate) _____ City _____ State _____ Zip code _____

Relationship, if Not the Patient _____ Witness Signature _____

(*If not signed by the patient, legal documentation will be required.)

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 #: _____