Hosp # _____

Van Buren County Hospital and Clinics
MyChart Caregiver Patient Access Application
Adult Access to the Electronic Medical Record of an Incapacitated Patient

Patient's Full Legal Name	Telephone Number	Date of Birth	Gender
Complete mailing address/street	City	State	ZIP Code

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 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.

Please print **Parent/Legal Guardian 1** Information:

Parent's/Legal Guardian's Full Legal Name	Telephone Number	Date of Birth	Gender
Complete mailing address/street	City	State	ZIP Code
E-mail Address	Relationship to patient (Optional)		

If applicable, please print **Parent/Legal Guardian 2** Information:

Parent's/Legal Guardian's Full Legal Name	Telephone Number	Date of Birth	Gender
Complete mailing address/street	City	State	ZIP Code
E-mail Address	Relationship to patient (Optional)		

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. This hospital does not require completion of this form as a condition of evaluation or treatment. I understand that my 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 at the address below. I verify the above named individual(s) have given verbal permission to receive their MyChart activation code via the e-mail address listed above. I have explained to them this may not be a secure means to receive information.

Signature of Parent/Legal Guardian 1 _____ Date _____

Signature of Parent/Legal Guardian 2 _____ Date _____

Mail Completed Form to: Van Buren County Hospital and Clinics
Release of Information/MyChart
304 Franklin Street
Keosauqua, IA 52565
Email Completed Form to: mychart_requests@vbch.org
Fax Completed Form to: 319-293-3046
Questions may be directed to: 319-293-3171

Internal use only: Verified and access entered by _____ Date _____