

**Van Buren County Hospital and Clinics  
MyChart Access Application  
Authorization to Allow Access to the Electronic Medical Record**

Hosp # \_\_\_\_\_

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

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. 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 via the U.S. mail or e-mail. I verify the above e-mail address is correct and approve receiving this confidential information (activation code) via this e-mail address. I understand this may not be a secure means to receive information.

Signature of Patient \_\_\_\_\_ 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 \_\_\_\_\_