Hospital #: ______________

MYCHART ACCESS APPLICATION

(Patient Access to the Electronic Medical Record)

University of Iowa Health Care (UI Health Care)
Health Information Management Department, Release of Information Office, 3281 Ridgeway Dr., Coralville, IA 52241
Telephone: 319-356-2555; Fax: 319-356-3079 or 319-353-7944; Email: him-consentform@uiowa.edu

Patient information (a separate form is required for each patient):

Patient's full legal name	Date of birth

Complete mailing address	City	State	Zip code

Email address	Mobile number

I understand this electronic access will be in effect until I notify Health Information Management listed above, to terminate this access and ends at the time of death.

This form is not needed for the patient to be evaluated or treated. I verify the above email address/mobile number is correct and approve receiving this confidential information via this email address/mobile number. I understand this may not be a secure means to receive information. I understand MyChart access can be revoked by UI Health Care at any time if not used appropriately.

Signature: ______________________________ **Date:** ____________________
(Patient or person legally authorized to consent for patient)

______________________________ ______________________________
(Printed name of patient or legally authorized person signing) (Relationship to patient or legally authorized person)

Once completed, return U.S. mail, fax, or email, as listed above.

Internal use only:
Verified and processed by: ______________________________ Date: ____________________

Revised: 5-2024