MyChart Adult/Adult Access Application
(Adult access to the Electronic Medical Record of another Adult)

Health Information Management Department/My Chart
901 Montgomery Street
Decorah, IA 52101
Telephone: 563-387-3100
Fax: 563-382-1506

____ ___________________________
Patient's full legal name Date of birth

_____________________________ _______________________ _______________ _______________
Complete mailing address City State Zip

____
Email address

2) If applicable, **Individual** information:

____ ___________________________
Patient's full legal name Date of birth

_____________________________ _______________________ _______________ _______________
Complete mailing address City State Zip

____
Email address

I am allowing the individual(s) named above to electronically view my WinnMed medical record Via MyChart.
This consent is voluntary. If I cancel this consent at a later date, I must notify Health Information Management listed above. If this consent is cancelled, I understand that information may have been released prior to the cancellation, and that action would not be considered a breach of confidentiality. I also acknowledge that: 1) recipients of this information ma possibly re-release the information without proper authorization, and 2) once information is disclosed it may no longer be protected by federal privacy regulations. I understand my WinnMed medical records includes information about any treatment I may have received for substance abuse, mental health, HIV-related condition, 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. I understand this electronic access will be in effect until revoked by the patient 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 I have received permission from the individual (s) listed to receive this confidential information via this email address/access can be revoked by WinnMed at any time if not used appropriately.

____ ___________________________
Patient's full legal name Date of birth

_____________________________ _______________________ _______________ _______________
Complete mailing address City State Zip

_______________________________________ _______________________________________
Relationship Witness Signature

*If not signed by the patient, list relationship, include witness signature, and legal documentation is required.

Once completed, return U.S. Mail or Fax as listed above

Internal use only:
Verified and processed by: ____ Date: _____________________