MERCY HOSPITAL, IOWA CITY, IOWA

MERCY PATIENT PORTAL ACCESS APPLICATION
AUTHORIZATION TO ALLOW
#9-67 (12/01/14)

Patient's full legal name (Please Print): _____ Date of Birth: _____ Gender: **M**_____ **F**_____

Complete mailing address: _____ City/State:_____ Zip code:_____

Email address (required): _____ Telephone: _____

I understand that by manually signing this form I am requesting access to my Mercy Patient Portal Record. Electronic/digital signatures are not accepted. I agree to the Terms of Use found on the Mercy Patient Portal Sign In page. I understand that this access will be in effect until I notify Clinical Information Services at the address below, in writing, to terminate this access. Access to the Mercy Patient Portal can be revoked at any time.

Your request will be processed within three business days of receipt. Additional instructions will be sent to the email address provided above. I verify the above email address is correct and approve receiving this confidential information (access code) via this email address. I understand this may not be a secure means to receive information.

Patient's Signature: _____ Date: _____

Mail completed form to:

OR

Mercy Hospital
Clinical Information Services
Attn: Release of Information Coordinator
500 E Market Street
Iowa City, IA 52245

Fax completed form to: 319-339-3785

Internal Use only: Verified and access provided by_____ Date_____