Alerts Delegation Form

** indicates required field*

* Last Name	* First Name	Middle Initial

* Title	* Credentials, if any (MD, DO, etc.)	Specialty

*** Participating Organization**

*** HIE User Account Name, if known:**

Provider Information:

Provider Name:

Provider NPI:

Additional Organizations that the Provider is employed at:

Delivery Options:

Direct Mail ** myAlerts Badge

Real Time

Daily Digest

**** Direct Mail Address for Alerts to be delivered to: *(leave blank if requesting new HealtheConnections Secure Mail account):***

***** Please note that if the provider treats patients at multiple facilities, Alerts will display all patient alerts from ALL facilities. *****

I authorize the delegate above to receive and view alerts on my behalf:

Signature*: ***Date:***

RHIO Administrator

Authorizing Signature*: ***Date:***

Authorizing Signature's Email Address: ***Title:***

PLEASE SUBMIT TO SUPPORT@HEALTHECONNECTIONS.ORG OR FAX TO 1-315-407-0053.