Public Health Access Audit Attestation

Facility Name:
Name:
Title:
Date:

☐ By checking this box, I agree that I have reviewed the Public Health Access report for DD/MM/YYYY to DD/MM/YYYY and verify that the information is accurate.

☐ By checking this box, I have reviewed the Public Health Access report for DD/MM/YYYY to DD/MM/YYYY and have identified any issue(s) below. I have either corrected the issue or will work with HealtheConnections to correct the issue.

Please type any issues here and indicate how they will be handled.

By signing below, I verify that the information I have provided is true.

Please return this completed form within 5 business days of receipt of the audit report to HealtheConnections Support at support@healtheconnections.org.

HealtheConnections Use Only

HealtheConnections Policy Officer Date