



HealthConnections RHIO Registration Application
Please send completed forms back to info@healthconnections.org

Date:

Organization Name:

Organization Address (include city and zip):

Alternative Address, if applicable:

Organization Phone:

Organization Fax:

Number of Providers:

MDs NPs PAs Techs

Organization Contact Information:

Name: Title: Phone: E-mail:

Alternative Contact Information:

Name: Title: Phone: E-mail:

Organization Type:

- | | |
|--|---|
| <input type="checkbox"/> Medical Practice | <input type="checkbox"/> Insurer |
| <input type="checkbox"/> Hospital | <input type="checkbox"/> Pharmacy |
| <input type="checkbox"/> Laboratory | <input type="checkbox"/> Public Health Dept |
| <input type="checkbox"/> Long Term Care | <input type="checkbox"/> Home Health Care |
| <input type="checkbox"/> Other (please specify): | |

Are you registering as (if registering as both please check both boxes and those that apply to your organization under each):

Data Provider (sends data to the RHIO). If so, please check which data types you plan on sending:

ADT ; System using:

Radiology; System using:

PACs; System Using:

Lab; System Using:

Transcribed Reports; System Using:

Other:

Data Recipient (pulls data from the RHIO). If so, please check which HealthConnections services you wish to use:

Clinical Messaging

VHR

ePrescribing

Does your organization use an EHR?

Please indicate EHR vendor:

Please indicate EHR product and version:

If accepted into the HealthConnections RHIO health information exchange, the organization will be asked to enter into a Participation Agreement which contains more detailed provisions regarding the rights and obligations of the organization.