Alerts User 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:**

Consent Based Alerts Options (Alerts for ALL patients consented at organization level):

☐ Direct Mail **
- ☐ Real Time
- ☐ Daily Digest

☐ SMS Text Message

Mobile Phone Number for Texting:

☐ myAlerts Badge

Alerts via badge are limited to 1 organization.

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

Provider Based Alerts Options (Alerts for providers named on report):

☐ Direct Mail **
- ☐ Real Time
- ☐ Daily Digest

☐ SMS Text Message

Mobile Phone Number for Texting:

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

By signing this document, I confirm that I have completed HIE training, read & understand the HIE access policies:

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.