HealtheConnections®

myResults 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:

Request Type:

☐ Add HIE User as Delegate for Provider listed above.

☐ Remove HIE User as Delegate for Provider listed above.

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

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.