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.