



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 ** SMS Text Message myAlerts Badge
- Real Time Mobile Phone Number for Texting: Alerts via badge are limited to 1 organization.
- Daily Digest

**** 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 ** SMS Text Message
- Real Time Mobile Phone Number for Texting:
- Daily Digest

**** 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 _____ **Title:** _____
Email Address: _____

PLEASE SUBMIT TO SUPPORT@HEALTHECONNECTIONS.ORG OR FAX TO 1-315-407-0053.