



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@HEALTHCONNECTIONS.ORG
OR FAX TO 1-315-407-0053.**