

Added Functionality Bulk User Form

* indicates required field

*** Participating Organization**

Please apply the following additional functions to the below Authorized User(s):

User Name	Change Access Type To:	Direct Mail	Perinatal Referrals	Transfer to PACS
_____	<input type="checkbox"/> Clinical <input type="checkbox"/> Demographics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/> Clinical <input type="checkbox"/> Demographics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/> Clinical <input type="checkbox"/> Demographics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/> Clinical <input type="checkbox"/> Demographics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/> Clinical <input type="checkbox"/> Demographics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/> Clinical <input type="checkbox"/> Demographics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/> Clinical <input type="checkbox"/> Demographics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/> Clinical <input type="checkbox"/> Demographics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/> Clinical <input type="checkbox"/> Demographics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/> Clinical <input type="checkbox"/> Demographics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/> Clinical <input type="checkbox"/> Demographics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/> Clinical <input type="checkbox"/> Demographics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

RHIO Administrator / Account Manager Signature:

Authorizing Signature*:

Dates:

Authorizing Signature's Email Address:

Title:

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