myData Enrollment Form

Practice Information	
Name of Practice/Organization (Primary):	

Attribution Lists Requested (Use Complete Name)	List Submitted to HeC (Y/N)

Authorized User(s) Information	
Authorized User Full Name:	***HealtheConnections User Name:***

By signing this document, I, the RHIO Administrator, approve access to myData for the User(s) noted above:

Authorizing Signature: ***Date:***

Authorizing Signature's Email Address: ***Title:***

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