# myResults Removal of Delegation

| Provider Information | |
|---|---|
| Provider Name: | |
| Name of Practice/Organization (Primary): | |
| Please list additional organizations or facilities: | |

| Delegate Information | |
|---|---|
| Name of Delegate to be removed: | Delegate HealtheConnections Username: |
| | |
| | |
| | |

I authorize the removal of the delegates(s) above. I no longer wish for them to receive and view results on my behalf.

Provider Signature:

Date:

Completed forms may be returned to support@healtheconnections.org or faxed to 1-315-407-0053.



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