eHealth Connect® Intelligent Health Record Aggregation
User Change Form

Add/ Delete	Name	Title	e-Mail Address	Phone	Fax	Specific Department (e.g. Pre Kidney TX)

I approve the above user(s) to be added/deleted from eHealth Technologies Access Service as indicated.

Please make these changes effective on: _____

If deleting user(s), please indicate which ***existing*** user any remaining records requests should be sent to: _____

By signing this form, I hereby submit that I am an authorized representative of the facility listed below and have the requisite authority to make this amendment on behalf of the facility.

Authorized Signature: _____ Title: _____ Date: _____

Print Name: _____ Facility: _____

PLEASE FAX TO: 877-606-4331 OR EMAIL TO: Account_Setup@eHealthTechnologies.com
FOR SUPPORT CALL: 877-344-8999 option 4