USER ACCOUNT FORM

HEALTHeLINK

Action

☑ New HEALTHeLINK Account
☐ Account Change
What is the change?_____

☐ New Authorized Contact _____
Choose a 4-digit PIN

Select One Authentication Method **– REQUIRED**

☑ Text Message to Cell#: _____
☐ Voice Call to Cell#: _____
☐ Voice Call to Direct Landline#:_____
☐ HEALTHeLINK Token
☑ My facility is a Trusted Site

User Information **– ALL FIELDS REQUIRED**

Last Name: _____ Legal First Name: _____
Date of Birth: _____Gender: EMR System/User ID:_____
User's Individual E-mail Address: _____ _____
Best way (phone or e-mail) to contact user directly:_ _____
Organization Name: Erie County Medical Center (ECMCC)
Department/Group *within* Organization: _____ Job Title: _____
Organization Address: 462 Grider Street
City: Buffalo State: NY Zip Code: 14215
Phone Number: _____ Fax Number: _____

HEALTHeLINK Access Type **– REQUIRED – SELECT ONE**

☐ MD/DO/Fellow
☐ PA/NP
☐ Resident
☐ Clinic Support Staff (Access to Results)
☐ Other Clinical Specialist (e.g., Dentist, Podiatrist, Pharmacist, PT/OT, etc.)
☐ Organ Transplant User
☐ Public Health User
☐ Coroner/Med Examiner
☐ Non-Clinical User (no results)
☐ Researcher
☐ Other (HeL internal use only): _____

Do you have an existing NYS Prescription Monitoring Program (I-STOP) account? ☐ Yes ☐ No

Do you need to manage consent? (If yes, select ONE method below) ☐ Yes ☑ No
☐ HEALTHeNET ☐ HEALTHeLINK Consent Management Application

THIS SECTION IS FOR PROVIDERS ONLY

Do you work in multiple locations? ☐ Yes ☐ No

Results Delivery Only? ☐ Yes (No access to web application) ☑ No

NPI: _____ NYS License#: _____

Authorized User Policy Attestation – http://wnyhealthelink.com/PhysiciansandStaff/Training
I have watched the HEALTHeLINK Policies Training Video or have read the Privacy & Security Policies and agree to comply with all applicable Policies and Procedures: _____ Date: _____

User Signature (Required)

Authorized Contact Approval – **AC SIGNATURE REQUIRED – DIFFERENT FROM THE USER**

I attest that I have verified the identity of the user named above in accordance with HEALTHeLINK policies and procedures:

_____ _____

Authorized Contact Signature (Required) **Date**

For HEALTHeLINK Internal Use Only – Other privileges
BTG Added_____ PCO added_____ Access to Part 2_____ Other _____