

AVOCARE HIN USER AUTHORIZATION FORM

DIRECTIONS: Licensed Providers (MD, DO, DDS, ARNP, etc) should fill out all of the sections and sign section 6. Employees of participating organizations must fill out sections 1 and 2, and then sign section 6.

1. User Contact Information. *(All users must be employed by an organization which is a contracted Participant to the Avocare HIN. All items in this section **MUST** be filled out. Please print clearly.)*

Organization Name: _____

Name of User: _____

Phone Number: _____

Email: _____

Mailing Address: _____

2. Statement of intended uses for information obtained from or submitted to the Avocare HIN. (Example: Patient check-in, referral management, patient care, etc.)

If you are a licensed provider, continue with sections 3 through 5. All others go to section 6.

3. Licensed Provider Information. *(Enter the information for the licensed provider)*

Provider Name: _____

Provider Type (MD, ARNP, etc): _____

Provider NPI #: _____

Provider Florida License #: _____

Provider Specialty: _____

4. Hospital Privileges:

	Yes	No
Do you have privileges at a hospital in the State of Florida?		

Other(s) *(list names)*: _____

5. Federal/State Health Insurance Program (OIG/GSA).

	Yes	No
Have you or any of your employees been suspended, sanctioned, or restricted from participating in any private, state or federal health insurance program (i.e. Medicare, Medicaid)?		

If yes, please provide details:

6. Attestation Statement:

I hereby request access to the Avocare Health Information Network. I understand that the information contained in the Avocare HIN is Protected Health Information (PHI) which I will use to provide care to patients with whom I have a relationship. I understand that PHI is regulated by federal (HIPAA) and state regulation, and inappropriate use of PHI is punishable by law.

All information I have provided in this Form is accurate. I understand that any significant misstatement in or omissions from this Form constitutes cause for denial or revocation of access.

I hereby agree that I will abide by the Avocare Health Information Network Terms of Use, currently in effect, and Registration Application both of which are incorporated herein by reference.

Furthermore, I will immediately notify Avocare in writing of any substantive changes to the information provided in this Form, or changes in User's employment status.

User's Signature

Date

Participating Organization Designee Signature

Date

Please complete and sign this form for each intended user of the Avocare HIN, then:

fax:
(850) 222-8771
Attention: Avocare HIN Services

or mail:
Avocare
Attention: Avocare HIN Services
3411 Capital Medical Blvd.
Tallahassee, FL 32308