PHYSICIAN PORTAL ACCESS REQUEST FORM

***Stared items are required**

***Organization Name:**_____ ***Department:**_____

***Physician Name:**_____ ***Business Phone:**_____

Business Address:_____

City:_____ **State:**_____ **Zip:**_____

***Email Address:**_____

***** _____
Printed Name of Physician

***** _____/_____ _____/_____
Physician Signature **Date** **Visiting Nurse Health System Director of MIS Approval** **Date**

Please fax completed form to 404-215-6005
Attention: Director, Health Information Management