PORTAL USER REGISTRATION FORM

Please Fax or Email Completed Form to:
(877) 739-7247 (f)
adriana.caraveo@triohealth.com

Questions? (858) 771-2500

User Information

Name: ________________________ MD DO NP RN PA MA Other: ____________

Work Email: ________________________ Mobile Phone: ________________ NPI : ____________ *(if applicable)*

NOTE: *Work Email address and mobile phone number are REQUIRED to receive a code and access encrypted account setup information.*

Practice Information

Practice Name: ________________________ Practice Type: Academic Community

Practice Phone: ________________

Prescribers For Whom You Have Authority to View PHI*

Prescriber 1 Name: ________________________ MD DO NP RN PA MA

NPI: ____________ Email: ________________________ Other: ____________

Prescriber 2 Name: ________________________ MD DO NP RN PA MA

NPI: ____________ Email: ________________________ Other: ____________

Prescriber 3 Name: ________________________ MD DO NP RN PA MA

NPI: ____________ Email: ________________________ Other: ____________

Prescriber 4 Name: ________________________ MD DO NP RN PA MA

NPI: ____________ Email: ________________________ Other: ____________

Prescriber 5 Name: ________________________ MD DO NP RN PA MA

NPI: ____________ Email: ________________________ Other: ____________

Prescriber 6 Name: ________________________ MD DO NP RN PA MA

NPI: ____________ Email: ________________________ Other: ____________

Prescriber 7 Name: ________________________ MD DO NP RN PA MA

NPI: ____________ Email: ________________________ Other: ____________

Prescriber 8 Name: ________________________ MD DO NP RN PA MA

NPI: ____________ Email: ________________________ Other: ____________

**Each individual practice site must be listed separately if access to PHI is required from multiple practice locations. Use additional forms if needed.*

Agreement for Access to Patient Information

Trio Health Advisory Group agrees to provide you access to the MDX Platform under the conditions that (1) you acknowledge you have the authority to access PHI from the prescribers provided; (2) you accept and comply with the Terms of Service and Business Associates Agreement (BAA) provided at first log in; and (3) you agree to notify Trio Health of any changes to your permissions to access PHI.

CONFIRMATION OF AGREEMENT

I, ________________________, hereby agree to access patient information per the terms provided above, and grant Trio Health permission to create a user account in my name allowing me access to PHI of the prescribers for which I am authorized.

Signature: ________________________ Date: ________________