

Western New York Clinical Information Exchange, Inc.
HEALTHeLINK Provider Registration Application

Please Type or Print Clearly

Date: _____

Organization name: _____

Number of Providers (includes MDs, NPs and PAs) _____

Organization Contact: _____ Alternate Contact: _____

Title: _____ Title: _____

Address: _____ Address: _____

City/Zip: _____ City/Zip: _____

Telephone: (____) _____ Telephone: (____) _____

Email: _____ Email: _____

Fax: _____ Fax: _____

Organization type: *(check one)*

Medical practice:

Pharmacy:

Laboratory:

Payor:

Hospital:

Other: _____

Panel size (# of patients): _____

Practice NPI: _____

Check which HEALTHeLINK services the Participant wishes to use.

Clinical Messaging _____

VHR _____

ePrescribe _____

Do you have an EMR? _____ If yes, please indicate EMR system: _____

Expected timeframe for connection: _____

If accepted into the HEALTHeLINK data exchange, the organization will be asked to enter into a Participation Agreement which contains more detailed provisions regarding the rights and obligations of the organization. Once completed, this Registration Application can be returned via fax to HEALTHeLINK at (716)206-0996 or mailed to: HEALTHeLINK, 2568 Walden Avenue, Suite 107, Buffalo, NY 14225.