



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

Please Type or Print Clearly

Date: _____

Organization name: _____

Number of Providers: MDs _____ NPs _____ PAs _____ Techs _____

Organization Contact: _____ Alternate Contact: _____

Title: _____ Title: _____

Address: _____ Address: _____

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

Email: _____ Email: _____

Fax: _____ Fax: _____

Organization type: *(check one)*

Medical practice:

Pharmacy:

Laboratory:

Payor:

Hospital:

Other: _____

Data type: *(check all that apply)*

ADTs: _____

Labs: _____

Rads: _____

Transcribed Reports: _____

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.