Request for Physician WebHHLA® Password

Please provide the following information. **(print clearly)**

Company Name: ______________________________ **City:** ____________________

Manager: ______________________________ **Date:** ____________________

Physician Name: ____________________ ______________________________
Last **First**

UPIN#: ______________________________

Email Address: ______________________________
NOTE: You must have a valid email address to receive a password.

HHLA has agreed to provide the client employee listed above with a secure ID and password in order to access patient results. By applying for Internet access, you agree to accept responsibility for protecting the integrity of your password. (This includes not sharing your password with others.) Data should only be accessed as it directly relates to patient treatment and/or location management.

By authorizing this request the manager agrees to notify HHLA if the user leaves the company.

______________________________ ____________________
Physician Signature Date

______________________________ ____________________
Manager Signature Date

Fax Requests to: (615) 771-0335 * Attn: Sales Support