GEISINGER HEALTH SYSTEM GEISINGERCONNECT
USER ACCESS REQUEST FORM ATTACHMENT B

Physician Practice/Site Name: ____ **Phone:** ______________

Communication Preference: FAX ☐ **Mail** ☐ **Email** ☐ **FAX:** ______________

First Name	Last Name	Last 4 SSN	DOB	Job Title (check appropriate column)					Grant Access to Medical Records	Employed by Practice	Vendor Of Practice	User Email Must be the submitting Company Owned email account linked to a user Johndoe@example.com
				RN	LPN	UDC	Admin	Other				
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Admin Contact Name & Title Date After Filling Out Print, Sign and FAX or Mail

Fax **this form to:** 570-214-1527 or
Mail to: Geisinger Health System, Epic Web Applications Production Support Team (60-15), 100 North Academy Avenue, Danville, PA 17822.

A User ID and one-time use activation code will be delivered to each individual listed above via the communication preference indicated. Each new user will log into Geisinger Connect to activate his/her account.