



CHANGE FORM

Please complete this fillable PDF, save and email to helpdesk@hawaiihie.org. Your request will be processed within seven business days. For immediate assistance, please contact Hawai'i HIE at helpdesk@hawaiihie.org or (808) 441-1374. NOTE: Completing this form as a fillable PDF ensures the information you provide is legible and this will enable faster processing. Mahalo!

Practice Information

Legal Name of Entity _____ Phone _____

Address _____ City _____ State _____ Zip Code _____

Provider/Staff Information

| Add | Remove | Provider/Staff Name | DOB | POC | DSA | NPI | State License | Specialty/Title | Email Address | Services Requested | | |
|-----|--------|---------------------|-------|-----|-----|-------|---------------|-----------------|---------------|--------------------|-----------|-----|
| | | | | | | | | | | CHR | Referrals | DSM |
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Practice Liaison Name
Please print first and last name

POC - Point of Contact (established liason between your practiuce and HHIE)
CHR - Community Health Record (patient search and records)

Signature
Please download PDF to use e-signature function

DSA - Designated Signing Authority (individual legally responsible for signing agreements on behalf of your practice)
DSM - Direct Secure Messaging Address (encrypted provider-to-provider email)

Date