

**CON TIGERCONNECT ACCOUNT REQUEST FORM**

Please complete one request form for each TigerConnect account needed. You may email this completed form to [hipaa@etsu.edu](mailto:hipaa@etsu.edu) or mail it to: East Tennessee State University, HIPAA Compliance Office, PO Box 70285, Johnson City, TN 37614.

To process your request, all information must be completed and the appropriate signatures must be present.

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[last] [first] [middle]

Title / Position \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Department / Clinic \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I am requesting a TigerConnect account be created  as soon as possible; or on \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_.

Please note: The VA does not allow VA patient information to be transmitted via TigerConnect.

By submitting this form, you confirm that you read and understood the “Secure Messaging Guidelines” found on the HIPAA Compliance website.  If you have questions about the guidelines for use, it is your responsibility to seek clarification from the ETSU HIPAA Compliance Office.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[signature of requestor] [date]

|  |
| --- |
| Account number to be billed: |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[signature of program director] [date]

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[signature of Dr. Kathryn Wilhoit] [date]

If you need additional information, please contact the HIPAA Compliance Office at 423.439.8533.

**This section for use by HIPAA Compliance Office**

|  |
| --- |
| **Date Received: Date Added to Organization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**    **□** **Adding additional account to department/clinic** **□ HIPAA Training verified**  **□ Replacing existing account for department/clinic**  **Account being replaced \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Notes:** |