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through technology

East Florida Division

PCP Notification Registration Form

Please fax completed form to (877)869-8530

Type of Request: ☐ SMS Text and/or ☐ Email ☐ Remove Access

Date of Request ________ Facilities: ________

Office Phone ________

Practice Name/Physician Name: ________

Office Address: ________

Primary Care Physician Notification: (If you are designated as the Primary Care Physician and would like to be notified via text and/or email that your patient has been seen or is in an HCA facility)

Cell Phone: ________ Email address: ________

Carrier: ________

Additional Staff to be notified: (Office Manager, etc.)

Cell Phone: ________ Email address: ________

Carrier: ________

Cell Phone: ________ Email address: ________

Carrier: ________

Physician Printed Name: ________ Date: ________

Physician Signature: ________