Children's Portal Designated User Registration Form

children's health
Children's Medical Center

Children's Health has implemented an enhanced identification validation process designed to help bolster the organization's security posture, as it relates to network account login and other access issues. **If you contact the Service Desk for assistance with login/password issues or account access**, the Service Desk may request that you validate the following information: **Mother's Maiden Name, Last four digits of Social Security Number and/or Date of Birth**

To designate access to Children's Medical Center's physician portal, complete the following information for your designated user(s). If you have any questions regarding the registration process, please call Provider Services at 214-456-9933.

Practice Information	
Practice Name:	
Address1:	
Address2:	
City, State, ZIP	
Phone:	
Fax:	
****Provider Email:**	

Please sign and return completed form by fax or email to:

Children's Health Systems of Texas
Physician Relations Department
fax: 214.456.5333
email: physicianrelations@childrens.com

Designated User(s)					****Required fields**				
First Name	**M I**	**Last Name**	**Office Title**	**Mother's Maiden Name**	****Date ofBirth**	****Last 4 digits of SSN**	****Email Address**	****Lic # and/or degree**	****NPI**
Ie. Jane	*L*	*Doe*	*Nurse*	*Smith*	*3/21/1960*	*1234*	*jane.doe@gmail.com*	*A1234*	*123456789*

I authorize the use of the Children's Portal (portal) by the person(s) listed above. These designated users shall only be entitled to access the portal while in my employ and under my supervision. I have communicated to these designated user(s) that access to the portal is limited to only information necessary to perform patient care related duties and/or as permitted by their job role. I agree to immediately inform Children's when one of my designated user(s) has terminated employment so that Children's may inactivate their access to protected health information.

Supervising Physician (Print Name) _____

Supervising Physician (Signature) _____

Date _____

Revised 11/24/2021