Individuals requiring access to data must submit an access request form to the SPHL. The SPHL will issue a user ID and password for each individual upon approval of this form.  
This form must be completed in its entirety; personal emails will not be accepted. The agency’s authorizing representative ‘s (i.e. Medical Director or Office Manager) signature must be present for the request to be processed. The authorizing representative’s signature confirms that the Agency fax number provided is a secure fax machine and proves that the requester has a business need to access patient information/results.

**Return this completed form via: Fax: 617-983-6399 or Email:** [elr.support@mass.gov](mailto:elr.support@mass.gov) *(response is quicker via email)*

*Please type or print the requested information.*

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| Agency Information |
| Agency Name:       Address:  Phone Number:       Fax Number: |
| User Information *(required)* **Effective Date:** |
| Request Type:  Add User  Terminate User  Suspend User  Resume User  Amend Access  Report Access:  Blood Lead VL1  TB2  VI3   Enteric4  None: e-Order entry access only Name (Last, First):  Email Address (*Business email)*:  Phone Number: |
| User Information *(required)* **Effective Date:** |
| Request Type:  Add User  Terminate User  Suspend User  Resume User  Amend Access  Report Access:  Blood Lead VL1  TB2  VI3   Enteric4  None: e-Order entry access only  Name (Last, First):  Email Address (*Business email)*:  Phone Number: |
| User Information *(required)* **Effective Date:** |
| Request Type:  Add User  Terminate User  Suspend User  Resume User  Amend Access  Report Access:  Blood Lead VL1  TB2  VI3   Enteric4  None: e-Order entry access only  Name (Last, First):  Email Address (*Business email)*:  Phone Number: |

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| Notes: |

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| **Agency’s Authorizing Representative**  Name (Last, First):       Title: |

**Authorizing Representative Signature: Date:**