PARTNERS HEALTHCARE SYSTEM, INC.
LMR DEACTIVATION REQUEST

AUTHORIZED USER:

Name (Last, First, Middle Initial): _____ Suffix (MD, PNP, etc.): _____

Gender: _____ Date of Birth: _____

Practice Name: _____

Practice Address: _____

Job Title: _____ User ID: _____ Practice Phone Number:_____

Reason for Deactivation:

- ☐ User Termination
- ☐ Changed to a position that no longer requires LMR access
- ☐ Other: _____

PRACTICE SUPER-USER

Super-User Name: _____ Date: _____

Fax completed form to: (857)-282-5912

Attn: Help Desk