# Houston Methodist EpicCare Link Order Delegation Release Form
## Multi-Provider Practice Staff

We hereby authorize our staff to act as our delegate for order entry through Houston Methodist EpicCare Link.  We acknowledge that we are required by law to co-sign any orders. Order entry capabilities may be suspended if orders have not been co-signed within <u>two business days</u>.

Please sign, date, and return the form to [epiccarelink@houstonmethodist.org](mailto:epiccarelink@houstonmethodist.org) so a ticket can be created and access changes can be built in the delegate record.

If you or your staff do not have EpicCare Link access, please submit a request at
https://www.houstonmethodist.org/epiccarelink/

_____          _____          _____
Provider Full Name (Print)          Provider Signature/Date          Provider NPI

_____          _____          _____
Provider Full Name (Print)          Provider Signature/Date          Provider NPI

_____          _____          _____
Provider Full Name (Print)          Provider Signature/Date          Provider NPI

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Provider Full Name (Print)          Provider Signature/Date          Provider NPI

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Provider Full Name (Print)          Provider Signature/Date          Provider NPI

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Provider Full Name (Print)          Provider Signature/Date          Provider NPI

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Provider Full Name (Print)          Provider Signature/Date          Provider NPI

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Provider Full Name (Print)          Provider Signature/Date          Provider NPI

_____          _____          _____
Provider Full Name (Print)          Provider Signature/Date          Provider NPI

_____  _____  _____
Delegate Full Name (Print)   Delegate Signature/Date   **Delegate Title** (if clinical staff)
(Example: MA, CMA, LPN, RN)

_____
Delegate EpicCare Link Username (ECLK######)


_____  _____  _____
Delegate Full Name (Print)   Delegate Signature/Date   **Delegate Title**
(Example: MA, CMA, LPN, RN)

_____
Delegate EpicCare Link Username (ECLK######)


_____  _____  _____
Delegate Full Name (Print)   Delegate Signature/Date   **Delegate Title**
(Example: MA, CMA, LPN, RN)

_____
Delegate EpicCare Link Username (ECLK######)


_____  _____  _____
Delegate Full Name (Print)   Delegate Signature/Date   **Delegate Title**
(Example: MA, CMA, LPN, RN)

_____
Delegate EpicCare Link Username (ECLK######)


_____  _____  _____
Delegate Full Name (Print)   Delegate Signature/Date   **Delegate Title**
(Example: MA, CMA, LPN, RN)

_____
Delegate EpicCare Link Username (ECLK######)


_____  _____  _____
Delegate Full Name (Print)   Delegate Signature/Date   **Delegate Title**
(Example: MA, CMA, LPN, RN)

_____
Delegate EpicCare Link Username (ECLK######)


_____
Clinic Name

_____
Clinic Address

_____          _____  _____
City                                State              Zip

_____          _____
Clinic Phone                        Clinic Fax

Revised: 04/2025