Client billing portal user request form
Add or removal

Allina Health
LABORATORY

Type or print clearly. *All fields are required in order for your request to be processed.*

Date	
Name (First MI Last)	
Title/Position	
Work email address	
Work phone number	
Office/facility name(s) and client/customer code(s) you work with:	

Add new user

☐ Receive/view invoices

☐ Receive & respond to client information requests required for insurance billing

I understand that I am responsible for any computing activity carried out using this account. I am aware that applicable laws prohibit the disclosure of patient information without the patient's consent.

Applicant's signature_____ **Date**_____

Delete/remove user

☐ Effective date: _____

Signature_____ **Date**_____

Sign, scan and email the completed form to AllinaHealthLaboratoryAccountRepresentatives@allina.com