



## Athena Role Change/Addition Authorization

By filling out this form and signing below, I acknowledge that SOM IT has fully and duly informed me of the potential for misuse and abuse of roles and permissions pertaining to the authorization of one or multiple clinics. I will be responsible for educating the employee of the consequences of misuse and abuse of roles and permissions. I will also absolve SOM IT of all responsibility resulting from abuse and misuse of roles and permissions pertaining to the authorization of one or multiple clinics.

Please write the information of the employee whom you are sponsoring below. If the employee works at multiple clinics and you would like this employee to have this authorization to one or multiple clinics, please specify below. All fields are required.

*\*\*Please note that it may take up to 2 business days for this request to be processed.*

Name: \_\_\_\_\_ Employee ID: \_\_\_\_\_ Phone: \_\_\_\_\_

Email: \_\_\_\_\_ Athena Username: \_\_\_\_\_

Job Title: \_\_\_\_\_

Current Role(s): \_\_\_\_\_

What new role(s) are you requesting for this employee?

☐ Billing Staff ☐ Clinic Front Desk Staff ☐ Clinical Staff

☐ Med Students (3rd & 4th Yr) ☐ Residents' Role ☐ Provider

☐ Other (please specify) \_\_\_\_\_

### Supervisor Signature

Printed Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Non-UTRGV Employees

- Copy of government issued photo ID required
- Sponsorship by Senior Director of Clinical Operations or Senior Director of Clinical Administration required

*Senior Director of Clinical Operations*

Printed Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*Senior Director of Clinical Administration*

Printed Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_