Medi-Cal
PROMOTING
INTEROPERABILITY
PROGRAM

Delegation of Authority

I, _____, authorize _____ to be my delegate for the purposes of registering for the Medi-Cal EHR Incentive Program. This document authorizes my delegate to enter the State Level Registry on my behalf, using my National Provider Number and Tax Identification Number to establish an account. My delegate will also be authorized to enter all registration information on my behalf for this and future years. However, I will personally review and sign the attestation form that verifies the accuracy of the information that my delegate will submit on my behalf.

I understand that I am not required to delegate my authority to register in the State Level Registry. My delegate will provide me with the user ID and password for my account and I understand that I can at any point change my user id and password so that I alone control my account.

Provider Signature: _____ Date: _____

Delegate Signature: _____ Date: _____