

HEALTH ACCESS & PRIVACY ALLIANCE

www.hapaindiana.org

MEMBERSHIP FORM

Organization Information:

Name of Organization _____

Postal Address _____

Email Address/Website _____

Telephone Number _____

Fax Number _____

Representative Information:

➤ Primary Representative _____

Email Address _____

Phone/Cell Number _____

➤ *Alternative Representative* _____

Email Address _____

Phone/Cell Number _____

___ Enclosed is \$25.00 for the annual dues payment for membership in the Health Access & Privacy Alliance.

___ Enclosed is an additional contribution of \$_____.

Please make check payable to the: **“Health Access and Privacy Alliance”**

Please send this form and your membership check to the HAPA Treasurer at:

Health Access & Privacy Alliance
c/o HAPA Treasurer
P.O. Box 397
Indianapolis, IN 46206