# Patient Medical Records Request Form

Healthix is a non-for-profit Qualified Entity (QE) certified by the NYS Department of Health to participate in the State Health Information Network of New York (SHIN-NY). Our mission is to develop, deploy and operate innovative uses of interoperable health information technology and analytics to facilitate patient-centric care and promote improved health care quality, affordability and outcomes for New Yorkers.

This form is used by a patient or their legal representative to request copies of medical records. To have this request processed, please fill it out and return either by faxing it to our secure eFax 877-331-1729 or by mail to Healthix, attention to Compliance Department, 551 North Road, 2nd Floor, St. James, NY 11780. *Note: To ensure privacy and security, records will not be released without providing proper identification upon receipt of this request by Healthix.*

1. **Costs Associated with Record Request**

   **Electronic/digital transmission** **No Charge**

   **Preparation of paper documents** **$0.75 per printed page plus shipping costs**
   Documents will be released upon payment. Options for payment include:

- Money order payable to:
  Healthix, Attn: Accounts Receivable/Record Request
  551 North Country Road, St. James, NY 11780

2. **Patient Information:**

Last: _____ First: _____ Middle: _____

Address: _____ Date of Birth: _____

Home/Cell Phone: _____ Relationship (circle): Self / Legal Representative

3. **Type of reports requested (check all that apply)**

☐ Copies of patient records in Healthix (note these records may not constitute the complete record from the contributing facility)

4. **Specify Date Range (MM/YYYY)** **From _____** **To _____**

5. **Delivery Instructions:** Please provide e-mail address and phone number for delivery

Email Address: _____ Telephone: _____

Mailing Address (if applicable – paper copies only): _____

_____

_____ _____

Patient Signature Date of Signature

**Name of Patient's Legal Representative** (if applicable) **signing on behalf of patient:**

_____ _____

Print Name/ Signature Date of Signature