



## 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, 121 West 36th St., #101, New York, NY 10018. *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  
121 West 36th St., #101  
New York, NY 10018

### 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