



Hixny Patient Portal Enrollment Form

Your personal health information is private, and Hixny uses the most advanced security and encryption to protect your privacy and keep your medical records safe. Therefore, we require a notarized request form to obtain a Hixny patient portal account.

Identity Verification and Authorization

Patient First and Last Name*		Gender*	Date of Birth*
Email Address*		Phone Number*	
Current Address (Including State and Zip Code)*			
Previous Address 1, if applicable (within the last 3 years, including State and Zip Code)*			
Previous Address 2, if applicable (within the last 3 years, including State and Zip Code)*			

* Required field

By signing this document, I represent that the information above is correct. I acknowledge that I am requesting a Hixny patient portal account be created.

Patient Signature

Date

Notarization:

STATE OF NEW YORK (COUNTY OF _____) ss:

On this _____ day of _____, in the year _____, before me personally came

_____, to me known and known to me to be the person

described in and who executed the foregoing instrument in my presence.

NOTARY PUBLIC: _____



Instructions to the Patient:

1. Fill in the information requested in the Identity Verification and Authorization section.
2. Please print clearly. Requests that are illegible will not be processed.
3. Sign and date the form in the presence of the notary.
4. Have the form notarized.
5. Mail the original completed form to Hixny at the address below. Photocopied, faxed or emailed copies or in-person requests will not be accepted.
6. Hixny may request further information prior to processing this form.

Mail completed form to:

Hixny
Attn: Support
80 Wolf Road
Suite 500
Albany, NY 12205