Hixny®

HIXNY-WIDE DENIAL OF ACCESS FORM

Authorization to Deny Access to Electronic Health Information
through a Health Information Exchange Organization

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

In completing this form, I request that electronic health information regarding my care and treatment NOT be accessed by ANY health care providers and health plans through Hixny, even in the event of an emergency. I understand that federal, state and local public health agencies, and certain organ procurement organizations, may still access my information in certain circumstances in accordance with applicable laws and regulations. I understand that the implementation of this denial is contingent upon me providing accurate demographic information that aligns with the demographic information I have provided to Hixny Participants. **I understand any consent I had previously granted to Hixny Participants will now be denied and any future consents I may grant will be denied UNLESS I contact Hixny and request a reversal.** I also understand that at any time, I may contact Hixny and request they reverse this request and again allow access to my records through Hixny.

The choice I make in this form will NOT affect my ability to get medical care or health insurance coverage.

☐ **I DENY CONSENT** for ALL health care providers and health plans participating in the Healthcare Information Xchange of New York, Inc. (Hixny) to access my electronic health information through Hixny, even in a medical emergency.

My questions about this form have been answered and I have been provided a copy of this form. I understand that I must complete and mail this notarized form to Hixny 80 Wolf Road, Suite 500, Albany, NY 12205 and that the change will become effective after this form is received by Hixny and recorded in its health information exchange system. I also understand that additional information can be found at https://hixny.org/hixny-for-patients/.

Signature of Patient or Patient's Legal Representative	Date of Signature
Print Name of Legal Representative (if applicable)	Authority to sign on behalf of patient (e.g., healthcare agent, guardian or parent)

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: _____