



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.

<input type="checkbox"/> 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.
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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)

<input type="checkbox"/> If this form is for an unemancipated minor (under age 18), please check this box to confirm you are the parent or legal guardian and authorized to make healthcare privacy decisions on the minor's behalf. All Hixny-wide denials will expire on the minor's 18th birthday, at which time they may resubmit the request if they wish to have it reinstated.
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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: \_\_\_\_\_



CHANGE OF HIXNY-WIDE DENIAL OF ACCESS FORM

Withdrawal of 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

I understand that the implementation of this denial is contingent upon me providing accurate demographic information that aligns with the demographic information I have previously provided to Hixny.

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

<input type="checkbox"/> <b>I WITHDRAW MY HIXNY-WIDE DENIAL OF ACCESS FORM.</b> I previously denied consent for any health care providers and health plans participating in Health Information Xchange of New York, Inc. (Hixny) to access my electronic health information through Hixny. I have changed my mind and want to allow access by such entities. Therefore, I hereby withdraw my prior denial of access form.
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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.

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)

<input type="checkbox"/> If this form is being supplied for a unemancipated minor patient (under the age of 18), please check this box to certify that you are the parent or legal guardian of the minor patient and you have the authority to make healthcare privacy decisions on their behalf.
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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: \_\_\_\_\_