

**NEW YORK STATE DEPARTMENT OF HEALTH  
OFFICE OF HEALTH INSURANCE PROGRAMS  
MEMBER REQUEST FOR SPECIFIC MEDICAID PROTECTED HEALTH INFORMATION**

Federal regulations permit you to request a specific designated record set. We will try to meet your request. If you wish to request this information, please complete the following:

Medicaid Member Name (required): \_\_\_\_\_

Date of Birth (required): \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**AT LEAST ONE OF THE FOLLOWING IDENTIFICATION NUMBERS IS REQUIRED, PREFERABLY BOTH.**

Client Identification Number (CIN): \_\_\_\_\_ Social Security Number (SSN): \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

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Street Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone Number: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

Dates of records requested – From: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ To: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Reason:

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Member Signature

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Date

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If not member, name of person signing for member

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Authority to sign on behalf of member

Please return to:

Medicaid Data Warehouse - CDRs  
NYSDOH – MISCNY  
ESP P1-11 S Dock J  
Albany NY 12237