

**NEW YORK STATE DEPARTMENT OF HEALTH
OFFICE OF HEALTH INSURANCE PROGRAMS
Enrollee/Patient 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:

Name: _____

Client Identification Number (CIN): _____

Date of Birth: _____

Street Address: _____

City: _____

State: _____ Zip Code: _____

Phone Number: _____

Dates of records requested: From: _____ To: _____

Reason:

Enrollee/Patient Signature

Date

Forward form to: New York State Department of Health
Office of Health Insurance Programs
Division of Systems - Bureau of Data Warehouse
Data Access Unit
800 N. Pearl Street
3rd Floor - Room 322
Albany, New York 12204