Hixny Patient Portal Form

Completing this form will establish access to the Hixny Patient Portal for you.

Patient's Information: (All sections must be completed. Please print clearly.)

Name (last, first, middle initial):_____

Social Security Number (last four digits):_____ Date of Birth: _____

Street Address:_____ City: _____

State:_____ Zip:_____ Phone Number: (_____) _____ - _____

Email Address:_____ @ _____

Hixny Patient Portal Terms and Agreement

I understand the portal is intended as a secure online source of confidential medical information. If I share my ID and password with another person, that person may be able to view my record.

I agree that it is my responsibility to select a confidential password, to maintain my password in a secure manner, and to change my password if I believe it may have been compromised in any way.

I understand that Hixny Patient Portal contains selected, limited medical information from a patient's medical record and that the Hixny Patient Portal does not reflect the complete contents of the medical record. I also understand that a paper copy of a patient's medical record may be requested from the Health Information Management Department of the Adirondack Medical Center.

I understand that use of the Hixny Patient Portal is voluntary and I am not required to use the Hixny Patient Portal or to authorize a proxy.

_____ _____

Patient Signature Date