Crystal Run Healthcare

Health Information Management Department
155 Crystal Run Road
Middletown, NY 10941
845-703-6999

61 Emerald Place
Rock Hill, NY 12775
845-794-6999
Fax: 845-703-3835

"Who is the patient?"

AUTHORIZATION For the Release of Health Information

Patient Name: Phone Number:

Address:
City, State, Zip

SS#: Date of Birth:
MM DD YY

I hereby authorize Crystal Run Healthcare to release my medical information to:

"Who is the authorized recipient?"

Name: _____ Attention of: _____

Street Address: _____ City, State, Zip: _____

Fax or Email: _____Phone: _____

"What are we authorized to send?"

☐ Medical Records from _____ to _____

☐ Dr. _____

☐ Entire Medical Record, including patient history, office notes, test results, radiology reports, referrals, consults, and records sent by other health care providers.

☐ Other**:** _____ ☐ Billing records _____

Include (indicate by initialing): _____ Alcohol/Drug Treatment _____ HIV Related Info and test results _____ Mental Health Information

Medical Records Copying Fees: $0.75 per page FORMAT: ☐ Paper Copy ☐ CD

☐ Films (dates): _____ **Film costs: ☐ $10.00 per sheet ☐ $5.00 CD**

Authorization to Discuss Health Information

"Who is the doctor authorized to speak to?"

☐ By initialing here _____, I authorize _____ to discuss my health information with:
Initials Name of individual health care provider

_____
(Name) **(Relationship)**

REASON FOR REQUESTED USE OR DISCLOSURE:

"Why is the information needed?"

☐ Personal Use ☐ Legal ☐ Second Opinion ☐ Change in health care provider

☐ Other (specify) _____

This authorization expires in 6 months from the date signed or earlier _____ .

TO BE READ AND SIGNED BY PATIENT:

I understand the following:

a. I may revoke this authorization at any time by providing written notice to the practice.
b. I may not be able to revoke this authorization if the practice has already taken action utilizing this authorization or if the authorization was obtained as a condition of obtaining insurance coverage.
c. The practice will not condition treatment or payment based on my signing this authorization.
d. I am signing this authorization freely and under no pressure from any individual to do so.
e. The information disclosed in this authorization may be subject to redisclosure by the practice and no longer protected by federal law.
f. I acknowledge that I have had an opportunity to review this authorization and understand the intent and use.
g. This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, and CONFIDENTIAL HIV RELATED INFORMATION only if I place my initials on the appropriate box above.
h. If I am authorizing the release of HIV related, alcohol, or drug treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal and state law. I understand that I have the right to request a list of people who may receive or use my HIV related information without authorization. If I experience discrimination because of the release or disclosure of HIV related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.

Signature of Patient or Legal Representative **Date:**

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