155 Crystal Run Road
Middletown, NY 10941

845•703•6999
www.crystalrunhealthcare.com

Patient Representative Form

Print Name: ______________________________________

Date of Birth: ______________________________________

Social Security Number: ___________/_____/___________

Patient Information

This permits Crystal Run Healthcare LLP to allow   , as designated below, to be present in the examination room, and I give permission to Crystal Run Healthcare, its practitioners, employees and representatives, to share all aspects of my medical care and treatment, and to discuss all payment issues, with such individual(s)*

Representative Information

Name of the Individual: ______________________________________

Date of Birth: ______________________________________

Address: ______________________________________

Telephone #: ______________________________________

Relationship to the Patient: ______________________________________

**A separate authorization must be completed to share highly sensitive information, such as HIV, alcohol and substance abuse treatment, or mental health information.*

Patient Signature ______________________________Date______________________

Witness ______________________________________