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: 845-796-5899

****CD PREFERRED****

Request for Medical Information

Patient Name:	Phone Number:
Address: City, State, Zip	
SS#:	Date of Birth: MM DD YY

The above-named patient is under the care of Crystal Run Healthcare. I hereby authorize the below provider to disclose my protected health information (information pertaining to my medical record) as indicated below:

(Fill in name and complete address of medical provider from whom information is being requested)

Physician and/or Provider: ____

Street Address: ______________________ City, State, Zip: ______________________

Phone and/or Fax: ____

THIS INFORMATION IS TO BE DISCLOSED TO: **Attention Doctor: ______________________**
Crystal Run Healthcare
Health Information Management Department
155 Crystal Run Road
Middletown, NY 10941
FAX: 845-796-5899

*****CD PREFERRED*****

DESCRIPTION OF INFORMATION TO BE DISCLOSED:
____
____

☐ All records
☐ For dates of treatment from ______________________ to ______________________

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

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

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 Request for Medical Information will expire 6 months from the date signed.

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