Crystal Run℠
Ambulatory Surgery Center

95 Crystal Run Road
Middletown, NY 10941
845•703•3800

Patient Information

Print Name ____

Date of Birth ____

Social Security Number __________/__________/__________.

I give permission to Crystal Run Ambulatory Surgery Center of Middletown, its practitioners, employees and representatives, to discuss all aspects of my medical care and treatment, including, but not limited to my protected health information, and to discuss all payment issues, with such individual(s) as designated below. *THIS FORM DOES NOT SERVE AS A NEW YORK STATE HEALTH PROXY OR HEALTH CARE POWER OF ATTORNEY.

Patient Representative Information

Name of Individual ____

Address ____

Telephone #____

Relationship to Patient ____

*a separate authorization must be completed to share highly sensitive information, such as HIV, alcohol and substance abuse treatment, and/or mental health information. THIS DOES NOT GRANT THE PATIENT REPRESENTATIVE THE RIGHT TO ACCESS PRINTED MEDICAL CHARTS OR INFORMATION AND DOES NOT GIVE THEM THE RIGHT TO REQUEST THEM ON THE PATIENT'S BEHALF. In order to revoke the right of the Patient Representative to discuss or otherwise access your PHI a revocation must be submitted to Crystal Run Ambulatory Surgery Center of Middletown.

Patient Signature ______________________________ Date______________