Crystal Run Healthcare

Health Information
Management Department
155 Crystal Run Road
Middletown, NY 10941

FAX BACK TO 845-703-3835

Request for Patient Access to their Protected Health Information

Patient Name: _____ Phone Number: _____

Street Address: _____ City, State, Zip: _____

DOB: _____ SSN: _____

Email: _____

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

_____ I am requesting ☐ **paper** ☐ **electronic** (via CD) copies of my medical information to be prepared for me to **pick-up** at (please circle) 155, 95, Rock Hill, Newburgh, Monroe, West Nyack (There may be a reasonable, cost based fee associated with this type of release.)

____ I am requesting ☐ **paper** ☐ **electronic** via CD or email copies of my medical information to be **sent:**

Name: _____ Attention of: _____

Street Address: _____ City, State, Zip: _____

Fax or Email: _____ Phone # for verification: _____

Please send my records via ☐ secure (recommended) ☐ unsecure (see below**) email

**Any medical information sent via unsecured e-mail is inherently not secure and could result in the information being read or otherwise accessed while in transit.

_____ Please include the last 2 years of my health information, including patient history, office notes, test results, radiology reports, referrals, consults, and records sent by other health care providers **or** specify what you would like released:

_____ Other: _____

_____ Doctor: _____

_____ Covering the period(s) of healthcare from: _____ to: _____

Indicate by initialing: _____ HIV/AIDS _____ Drug/Alcohol _____ Psychotherapy

If you do not initial, this protected health information will not be released

Signature of Patient or Legal Representative (documentation attached or on file):

_____ Date: _____

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