Crystal Run Ambulatory Surgery Center
95 Crystal Run Road
Middletown, NY 10941
845•703•3800
www.crystalrunhealthcare.com

Patient Representative Authorization Form

Patient Name: _____

Date of Birth:_____Social Security Number: _____

PLEASE NOTE: This form does not serve as a New York State Health Care Proxy or Health Care Power of Attorney

Patient Representative Information

I hereby give permission to Crystal Run Healthcare, 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 the individual designated below;

Name of the Individual: _____

Relationship to Patient: _____

Date of Birth: _____Telephone#: _____

Address: _____

Patient Signature:_____Date: _____

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 rights of the Patient Representative listed above, a new form must be completed with updated information.