Crystal Run Healthcare

Health Information Management Department
HIM@crystalrunhealthcare.com

155 Crystal Run Road
Middletown, NY 10941
Phone 845-703-6999

AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION

Patient Name: _____ Date of Birth: MM_____DD_____YY_____
Address:_____ Phone:_____
City, State, Zip : _____

I hereby authorize Crystal Run Healthcare to release my medical information to:
Name: _____ Attention of: _____
Street Address: _____ City, State, Zip:_____
Fax or Secure Email: _____ Phone:_____

Records Being Requested (Indicate below which records you are requesting and fill in as appropriate)

☐ Date(s) of service:_____ Provider(s): _____
☐ Operative Procedure/Reports: _____
☐ Last two (2) years of Health Information
☐ Office Visit(s) _____
☐ Test Results (Lab/Pathology results) Please Specify: _____
☐ Radiology (X-ray, CT scan, MRI): Reports Only _____ Imaging on CD_____
☐ Other (Please specify): _____

Include *(Indicate by Initialing*)*

___HIV/AIDS ___Drug/Alcohol ___Mental Health ___Genetic Testing ___Reproductive Testing

***IF YOU DO NOT PLACE INITIALS, THIS PROTECTED HEALTH INFORMATION WILL NOT BE RELEASED TO A 3RD PARTY**

How would you like your records delivered?

☐ Paper
☐ Electronic: Email (encrypted) _____
☐ Fax # _____
☐ Other (Please specify) _____

Authorization to Discuss Health Information

☐ By initiating here ___, I authorize _____ to discuss my health information with:
Initials Name of individual health care provider
Name:_____ Relationship:_____

REASON FOR REQUESTED USE OR DISCLOSURE:

☐ Personal Use ☐ Legal ☐ Second Opinion ☐ Change in health care provider
☐ Other (specify) _____

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. Information disclosed under this authorization might be re-disclosed by the recipient and this re-disclosure may no longer be protected by federal or state law.
f. I acknowledge that I have had an opportunity to review this authorization and understand the intent and use.
g. This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE and CONFIDENTIAL HIV RELATED INFORMATION only if I place my initials on the appropriate box above.
h. If I am authorizing the release of HIV related, alcohol, or drug treatment information, the recipient is prohibited from re-disclosing such information without my authorization unless permitted to do so under federal and state law. I understand that I have the right to request a list of people who may receive or use my HIV related information without authorization. If I experience discrimination because of the release or disclosure of HIV related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.

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