



**Health Information  
Management Department**  
**155 Crystal Run Road**  
Middletown, NY 10941  
845-703-6999

Fax: 845-703-3835  
HIM@crystalrunhealthcare.com

**\*\*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:** \_\_\_\_\_

**\*\*CD PREFERRED\*\***

**Crystal Run Healthcare**  
**Health Information Management Department**  
**155 Crystal Run Road**  
**Middletown, NY 10941**  
**FAX: 845-703-3835**  
**HIM@crystalrunhealthcare.com**

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:

- I may revoke this authorization at any time by providing written notice to the practice.
- 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.
- The practice will not condition treatment or payment based on my signing this authorization.
- I am signing this authorization freely and under no pressure from any individual to do so.
- The information disclosed in this authorization may be subject to redisclosure by the practice and no longer protected by federal law.
- I acknowledge that I have had an opportunity to review this authorization and understand the intent and use.
- This Request for Medical Information will expire 6 months from the date signed.

Signature of Patient or Legal Representative: \_\_\_\_\_

Date: \_\_\_\_\_