Crystal Run Healthcare

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

61 Emerald Place
Rock Hill, NY 12775
845-794-6999

Patient Information

Print Name _____

Date of Birth _____

Social Security Number _____/_____/_____

This permits Crystal Run Healthcare LLP to allow _____, as designated below, to be present in the examination room, and I 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 such individual(s)* THIS FORM DOES NOT SERVE AS A NEW YORK STATE HEALTH PROXY OR HEALTH CARE POWER OF ATTORNEY.

Patient Representative Information

Name of the Individual _____

Date of Birth _____

Address _____

Telephone # _____

Relationship to the 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 rights of the Patient Representative to discuss or otherwise access your PHI a revocation must be submitted to Crystal Run Healthcare LLP.

Patient Signature _____ Date_____