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

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www.crystalrunhealthcare.com

Request for Patient Access to Their Protected Health Information

Patient Information (Please Print):

First Name: _____ Middle Initial: _____ Last Name: _____

(Also known as): _____

Date of Birth (MM/DD/YYYY): _____ Phone: _____ E-mail: _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

I Authorize CRHC to Release my Records. Where do you want the information sent?

Recipient Name: _____ Recipient Phone: _____

Recipient Mailing Address: _____

Recipient E-mail/Fax: _____

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

☐ Specific 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 OR Imaging on CD

☐ Other Please Specify: _____

To include additionally protected health information*, please indicate by initialing:

_____**HIV/AIDS** _____**DRUG/ALCOHOL** _____**PSYCHOTHERAPY**

***IF YOU DO NOT PLACE INITIALS, THIS PROTECTED HEALTH INFORMATION WILL NOT BE RELEASED**

How would you like your records delivered?

☐ **CD** ☐ **Paper -** Mail or Pickup (Locations: 155, 95, Rock Hill, Newburgh, New Windsor, Monroe, West Nyack)

☐ **Electronic:** Email (secured or unsecured) _____@_____ or Fax (#) _____

☐ **Other**: (Please Specify) _____

Name of Patient or Legal Representative: (PLEASE PRINT) _____

Relationship: _____
(DOCUMENTATION MUST BE ATTACHED OR ON FILE)

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

PLEASE RETURN OR FAX THE COMPLETED FORM TO THE ABOVE ADDRESS

Crystal Run Healthcare recognizes a patient's right under HIPAA to access copies of their health information. There may be charges associated with processing a request and producing records.