Crystal Run Healthcare
155 Crystal Run Road
Middletown, NY 10941
www.crystalrunhealthcare.com
Phone 845•703•6999
Fax 845•703•3835

Request for Patient Access to Their Protected Health Information

Patient Information (Please print):

Patient Name (Last name, First Name) _____ Date of Birth _____
Street Address:
_____
City: _____ State: _____ Zip: _____
Phone #_____ Email: _____

I authorize CRHC to release my records. Where do you want the information sent?

To: _____ Phone #_____

Fax #_____
Mailing Address: _____
City: _____ State: _____ Zip: _____
Email: _____

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) _____

Name of Patient or Legal Representative (Please Print) _____
Signature of Patient or Legal Representative: _____
Relationship (Documentation must be attached or on file) _____
Date: _____

Please return form to the above address Attn: Health Information Management. You may also email HIM@crystalrunhealthcare.com

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.