 ***Fax back to 845-703-3835***

95 Crystal Run Road

Middletown, NY 10941

**Request for Patient Access to Their PHI**

This form is for patient initiated requests to receive or send copies of their own medical information

**from Crystal Run Healthcare**

1. Patient Name (Please Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3. SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Please check all that apply to your request:

\_\_\_\_ I am requesting 🞎 **paper** 🞎 **electronic** (via CD) copies of my medical information to be prepared for me to **pick-up** at (please circle) 155, 95, Rock Hill, Newburgh, Monroe, West Nyack (There may be a reasonable, cost based fee associated with this type of release.)

\_\_\_\_ I am requesting 🞎 **paper** 🞎 **electronic** via CD or email copies of my medical information to be **sent**

Physical address for sending paper copies or CD: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-Mail address for sending electronic copies:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone for verification of fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please send my records via 🞎 secure (recommended) 🞎 unsecure (see below\*\*) email.

\*\*Any medical information sent via unsecured e-mail is inherently not secure and could result in the

information being read or otherwise accessed while in transit.

1. \_\_\_\_\_ Please include the last 2 years of my health information, including patient history, office notes, test results, radiology reports, referrals, consults, and records sent by other health care providers **or** specify what you would like released:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Covering the period(s) of healthcare: FROM (Date): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ TO (Date): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Initial \_\_\_\_\_\_ HIV/AIDS \_\_\_\_\_\_ Drug/Alcohol \_\_\_\_\_ Psychotherapy

\*\*If you do not initial, protected health information will not be released\*\*

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **or**

Legal Personal Representative (documentation attached or in file): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

6/17 v.1