Crouse
MEDICAL PRACTICE

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION FOR CONTINUED CARE

PATIENT NAME: _____ **DOB:** _____/_____/_____

ADDRESS: _____

_____

I authorize Crouse Medical Practice ("CMP") to provide me with a copy of orders, lab results, imaging results, EKGs, pulmonary function tests, Durable Medical Equipment prescriptions and work notes when I request them at an office visit or when I call the office and make a request. Further, I also authorize CMP to send me the above via postal mail or my patient portal account upon request. I understand the most secure way to receive this information is via the patient portal. The purpose of this request is for my ongoing medical care.

I understand that I can revoke this request at any time and that this request is valid unless otherwise revoked by me. This request does not permit the release of my entire medical record, however, if I wish to receive further information than what is listed above, I can request this via completing an Authorization for Release of Health Information Form #200-14F (available on www.crousemed.com, or CMP staff can provide you with a copy), or, another type of written request can be accepted as long as it contains the minimum information needed in order to process the request.
I also fully understand that I will be required to sign an authorized release of information form if I am requesting that my records be sent to another entity or person.

The format I wish to receive the aforementioned information in is:

☐ Paper format

☐ CD

☐ Encrypted e-mail to email address: _____

☐ *Unencrypted e-mail to email address: _____

☐ *Fax: to fax # _____

Be advised that all requests to receive via email are processed by CIOX Health.
Be advised for any patient access requests for your own records, the following fees apply:

- Paper copy = $0.90 flat fee plus $0.05 per page not to exceed $6.50,
- CD = $6.50,
- E-mail = $6.50,
- Fax = $6.50,
- Patient portal = Free of charge

*If we send you your protected health information via unencrypted e-mail or fax, there is some level of risk that the information within the e-mail (attached or in body) or in the fax could be read or otherwise accessed by a third party while in transit. Be aware that anyone you've given access to your e-mail account or fax may be able to access/view/store your information regardless of if the e-mail is sent encrypted or unencrypted. If sent unencrypted, the terms and conditions of the service provider/product you use may involve a third party being able to access and/or store the information. If you accept these risks, and we comply with your request to send you the information in an unsecure manner, CMP is not responsible if the information is intercepted in transit nor are we responsible for unauthorized access to your information once it's been delivered to you. **By signing below, you confirm the selection above for the form/format you wish to have your protected health information sent and accept the above risks associated with e-mail/fax if that's the option you chose.**

Patient Signature: _____ Date: _____ Time _____

CMP Witness Signature: _____ Date: _____ Time _____