

Certified Release of Information Specialist (CRIS) Certification Practice Test (Sample)

Study Guide



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SAMPLE

Questions

- 1. What action should be taken when a patient authorizes the release of their information?**
 - A. Release the information without additional verification**
 - B. Verify any specific conditions mentioned in the authorization**
 - C. Only release information if it's for medical emergencies**
 - D. Complete the request without any checks**
- 2. Which of the following reports may be hand-written at the start of progress notes?**
 - A. Discharge Summary**
 - B. Electrocardiogram Report**
 - C. History and Physical**
 - D. Continuation of Care Document**
- 3. How do the duties of a CRIS impact patient care?**
 - A. They focus solely on administrative tasks**
 - B. They help protect patient privacy and facilitate timely communication**
 - C. They reduce the number of staff in healthcare settings**
 - D. They primarily address billing disputes**
- 4. If a patient completes an authorization form, can they state "at the request of the patient" as the purpose for disclosure?**
 - A. Yes**
 - B. No**
 - C. Only if clarified**
 - D. Only if signed by the patient**
- 5. What should a person do if they suspect fraud involving their identity in medical records?**
 - A. Request a copy of the record immediately**
 - B. Inform the facility, but they cannot access another's record**
 - C. Send a formal complaint to the insurance company**
 - D. Call the police**

- 6. What is a Certification in the context of healthcare records?**
- A. A form completed by an attorney certifying that they received all the records that they requested**
 - B. A form completed by the records custodian or agent certifying that they provided all records requested and that the records provided are true and complete copies of the original**
 - C. A form completed by a healthcare provider certifying that the information in the electronic health record is accurate and true**
 - D. A form completed by the patient certifying that she/he has provided the names of all of his/her healthcare providers**
- 7. What type of information may be included in the Designated Record Set?**
- A. Financial audits of the healthcare facility**
 - B. Records from other facilities used in treatment**
 - C. Internal policies of the healthcare provider**
 - D. Patient demographic information only**
- 8. What fees charged to a patient for copies of PHI under HIPAA cannot include?**
- A. Copying cost including labor**
 - B. Retrieval or handling fees**
 - C. Actual postage**
 - D. All of the above**
- 9. What actions can a patient take if they wish to dispute a breach of their PHI?**
- A. File a complaint with the provider**
 - B. Inform the media**
 - C. Contact law enforcement**
 - D. Request assistance from a lawyer**
- 10. Which scenario demonstrates a situation where special authorization is necessary?**
- A. Request for general medical record copies**
 - B. Disclosure of chemical dependency treatment**
 - C. Request from a family member without medical consent**
 - D. Routine medical information disclosed for educational purposes**

Answers

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- 1. B**
- 2. C**
- 3. B**
- 4. A**
- 5. B**
- 6. B**
- 7. B**
- 8. B**
- 9. A**
- 10. B**

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Explanations

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1. What action should be taken when a patient authorizes the release of their information?

- A. Release the information without additional verification**
- B. Verify any specific conditions mentioned in the authorization**
- C. Only release information if it's for medical emergencies**
- D. Complete the request without any checks**

When a patient authorizes the release of their information, it is essential to verify any specific conditions mentioned in the authorization. This step ensures compliance with applicable laws and regulations regarding the confidentiality and privacy of medical records. The authorization may include specific details such as the type of information to be disclosed, the purpose of the disclosure, and any expiration date or conditions under which the authorization remains valid. By carefully verifying these conditions, healthcare providers can ensure they only release the information that the patient has explicitly authorized, ultimately safeguarding patient privacy and adhering to legal requirements. This process demonstrates respect for the patient's wishes and helps prevent unauthorized disclosures, which could lead to legal implications or breaches of trust. The other options do not adequately prioritize patient privacy and compliance with regulations. Simply releasing information without verification or checks could lead to unauthorized data sharing, while restricting releases solely to medical emergencies ignores the broader context of the patient's authorization.

2. Which of the following reports may be hand-written at the start of progress notes?

- A. Discharge Summary**
- B. Electrocardiogram Report**
- C. History and Physical**
- D. Continuation of Care Document**

The correct option is indeed the History and Physical report. Hand-written notes or entries in a patient's medical record, particularly during the initial assessment, are traditionally acceptable in this context. The History and Physical report serves as a comprehensive overview of a patient's medical history and current health status, often compiled at the beginning of treatment. In clinical practice, these notes are crucial for establishing a baseline and guiding subsequent care. Since this document is often the first significant entry in the medical record, it allows healthcare providers to make immediate evaluations and decisions. Other types of reports mentioned, such as a Discharge Summary, Electrocardiogram Report, and Continuation of Care Document, are typically more formalized and tend to follow specific standardized formats or electronic health record protocols, which usually discourage hand-written entries in favor of typed or electronically documented information.

3. How do the duties of a CRIS impact patient care?

- A. They focus solely on administrative tasks
- B. They help protect patient privacy and facilitate timely communication**
- C. They reduce the number of staff in healthcare settings
- D. They primarily address billing disputes

The duties of a Certified Release of Information Specialist (CRIS) significantly impact patient care by ensuring that patient privacy is safeguarded while also facilitating the timely exchange of important health information. By managing the release of medical records and information responsibly, a CRIS ensures that healthcare providers have access to the necessary data to make informed decisions regarding patient care. This role is essential in maintaining compliance with legal regulations like HIPAA, which protects patient confidentiality. When patient data is handled properly, it leads to improved coordination among healthcare teams, quicker diagnosis, and faster treatment plans, all of which enhance the overall quality of care that patients receive. Therefore, the ability of a CRIS to manage these processes effectively plays a crucial role in promoting both patient privacy and care efficiency, ultimately benefiting the patient experience in healthcare settings.

4. If a patient completes an authorization form, can they state "at the request of the patient" as the purpose for disclosure?

- A. Yes**
- B. No
- C. Only if clarified
- D. Only if signed by the patient

The assertion that a patient can state "at the request of the patient" as the purpose for disclosure is valid. This phrase signifies that the patient is the one initiating the request for their own health information to be shared. It aligns with the fundamental principle that individuals have the right to control their own health information and can authorize its release for various purposes, including personal use or further medical care. In many cases, healthcare regulations, such as the Health Insurance Portability and Accountability Act (HIPAA), emphasize the importance of patient consent and highlight the importance of patients being informed about their rights regarding the use and disclosure of their health information. By allowing the phrase, it shows the patient's agency in the disclosure process. The other options suggest limitations or conditions that may not typically be required under the law. For instance, while additional clarity may sometimes enhance understanding, a specific phrase like "at the request of the patient" is straightforward and widely accepted. Similarly, the necessity for a patient's signature or additional stipulations does not apply to this general practice, as the patient's completion of the authorization form itself signifies consent for the stated purpose.

5. What should a person do if they suspect fraud involving their identity in medical records?

- A. Request a copy of the record immediately**
- B. Inform the facility, but they cannot access another's record**
- C. Send a formal complaint to the insurance company**
- D. Call the police**

The most appropriate action in the case of suspected fraud involving one's identity in medical records is to inform the facility about the matter. By notifying the facility, the individual initiates an important step in addressing potential identity theft and fraud. The healthcare facility has the protocols in place to investigate discrepancies and can take necessary actions to protect the individual's medical records and ensure accurate information is maintained. The facility will typically have a process for handling complaints or reports of fraudulent activity. While the person reporting cannot access another's record due to privacy laws, they can certainly inform the facility so that appropriate measures can be put into place to rectify any issues with their medical information. Requesting a copy of the record immediately may seem like a necessary step, but it's essential first to notify the appropriate personnel about the suspicion of fraud, ensuring that any potential risks are managed correctly. Sending a formal complaint to the insurance company does not address the immediate concern directly with the healthcare provider and can complicate the resolution process. Calling the police could be warranted in cases of direct theft or clear criminal acts, but the first step should be communicating with the healthcare facility to ensure they can investigate and take actions to protect the individual's rights and health information.

6. What is a Certification in the context of healthcare records?

- A. A form completed by an attorney certifying that they received all the records that they requested**
- B. A form completed by the records custodian or agent certifying that they provided all records requested and that the records provided are true and complete copies of the original**
- C. A form completed by a healthcare provider certifying that the information in the electronic health record is accurate and true**
- D. A form completed by the patient certifying that she/he has provided the names of all of his/her healthcare providers**

In the context of healthcare records, the certification process is a crucial step that involves the custodian of the records, often referred to as the records custodian or agent. This form serves to validate that the records provided in response to a request are complete and true duplicates of the originals. The custodian, who is responsible for maintaining and safeguarding these records, ensures that the integrity of the information is upheld and confirms that no information has been omitted or altered. This form of certification is important in medical and legal contexts, as it provides assurance to all parties that the data shared from the medical record is both accurate and comprehensive. Such a certification helps foster trust in the handling of sensitive patient information, which is essential in healthcare operations, compliance with regulations, and legal accountability. Other options present forms that address various aspects of record handling but do not reflect the specific role of the records custodian in certifying the accuracy and completeness of the records provided in response to requests. For example, while forms related to attorney certifications or provider information exist, they do not encapsulate the primary responsibility of ensuring the authenticity and completeness of healthcare records, which is inherently tied to the role of the records custodian.

7. What type of information may be included in the Designated Record Set?

- A. Financial audits of the healthcare facility**
- B. Records from other facilities used in treatment**
- C. Internal policies of the healthcare provider**
- D. Patient demographic information only**

The Designated Record Set is a term defined under the Health Insurance Portability and Accountability Act (HIPAA) that encompasses a specific collection of medical and billing records maintained by a healthcare provider. This includes any records that are used to make decisions about a patient's care. In this context, including records from other facilities used in treatment is consistent with how the Designated Record Set is structured. It may encompass any documentation of care that influences patient treatment, which could include referrals, previous medical history, and records from specialists or hospitals outside the primary healthcare provider's system. This interconnectedness ensures comprehensive patient care and maintains continuity in treatment, as it facilitates informed decision-making based on complete information. On the other hand, financial audits of the healthcare facility, internal policies of the healthcare provider, and merely patient demographic information are not typically components of the Designated Record Set. Financial audits are administrative documents that do not contribute directly to patient care decisions, while internal policies guide organizational conduct rather than providing clinical information relevant to individual patients. Patient demographic information, though necessary for identification and billing, does not encompass the full scope of healthcare records that would fall under the Designated Record Set.

8. What fees charged to a patient for copies of PHI under HIPAA cannot include?

- A. Copying cost including labor**
- B. Retrieval or handling fees**
- C. Actual postage**
- D. All of the above**

Under HIPAA, when a patient requests copies of their protected health information (PHI), covered entities can only charge for specific types of fees related to the copying of those records. The law allows for charges that are directly related to the costs of providing those copies, which can include actual copying costs and postage. The correct answer highlights that retrieval or handling fees cannot be charged to the patient. This is because HIPAA stipulates that fees for copies of PHI are limited strictly to the costs associated with the copying itself and any necessary shipping, if applicable. The reasoning behind this regulation is to prevent excessive charges that could act as a barrier for individuals seeking access to their own health information. In contrast, actual copying costs, which may involve labor and materials for creating the copies, as well as postage to send the records to the patient, are permissible charges under HIPAA regulations. These guidelines help ensure that patients have affordable access to their medical records while preventing overcharging for the obtaining of their own health information.

9. What actions can a patient take if they wish to dispute a breach of their PHI?

- A. File a complaint with the provider**
- B. Inform the media**
- C. Contact law enforcement**
- D. Request assistance from a lawyer**

When a patient wishes to dispute a breach of their Protected Health Information (PHI), filing a complaint with the provider is a direct and appropriate action. This step allows the patient to formally notify the healthcare entity about the breach, enabling the provider to investigate the circumstances of the incident. Providers are required to have procedures in place to handle such complaints under the Health Insurance Portability and Accountability Act (HIPAA). By initiating this process, the patient can seek resolution and ensure that their rights regarding privacy and security of health information are upheld. In many cases, the provider may take corrective action, implement changes to prevent future incidents, or provide insights into how the breach may have occurred. While informing the media or contacting law enforcement could be options in certain circumstances, they do not typically serve as the first course of action in disputing a breach of PHI and could complicate matters further. Seeking assistance from a lawyer is also a potential route for a patient, but it is generally more effective to first address the issue directly with the provider, as this allows for resolution within the healthcare system itself before escalating the situation.

10. Which scenario demonstrates a situation where special authorization is necessary?

- A. Request for general medical record copies**
- B. Disclosure of chemical dependency treatment**
- C. Request from a family member without medical consent**
- D. Routine medical information disclosed for educational purposes**

The scenario that illustrates the need for special authorization involves the disclosure of chemical dependency treatment. This is due to the heightened privacy protections that apply to sensitive information regarding substance abuse treatment. Specific regulations, such as those outlined in 42 CFR Part 2, mandate that entities must obtain explicit consent from the patient before sharing information related to chemical dependency treatment. This requirement ensures that individuals receiving treatment for substance use disorders have additional safeguards protecting their privacy, recognizing the stigma and potential legal ramifications that can arise from such disclosures. In contrast, general medical record copies, routine medical information for educational purposes, and requests from family members without medical consent typically do not necessitate special authorization. These scenarios either involve information that does not have the same level of privacy protection or are governed by broader consent regulations that do not require heightened scrutiny. Thus, the need for special authorization is a critical consideration when dealing with sensitive health information, particularly in the context of chemical dependency.