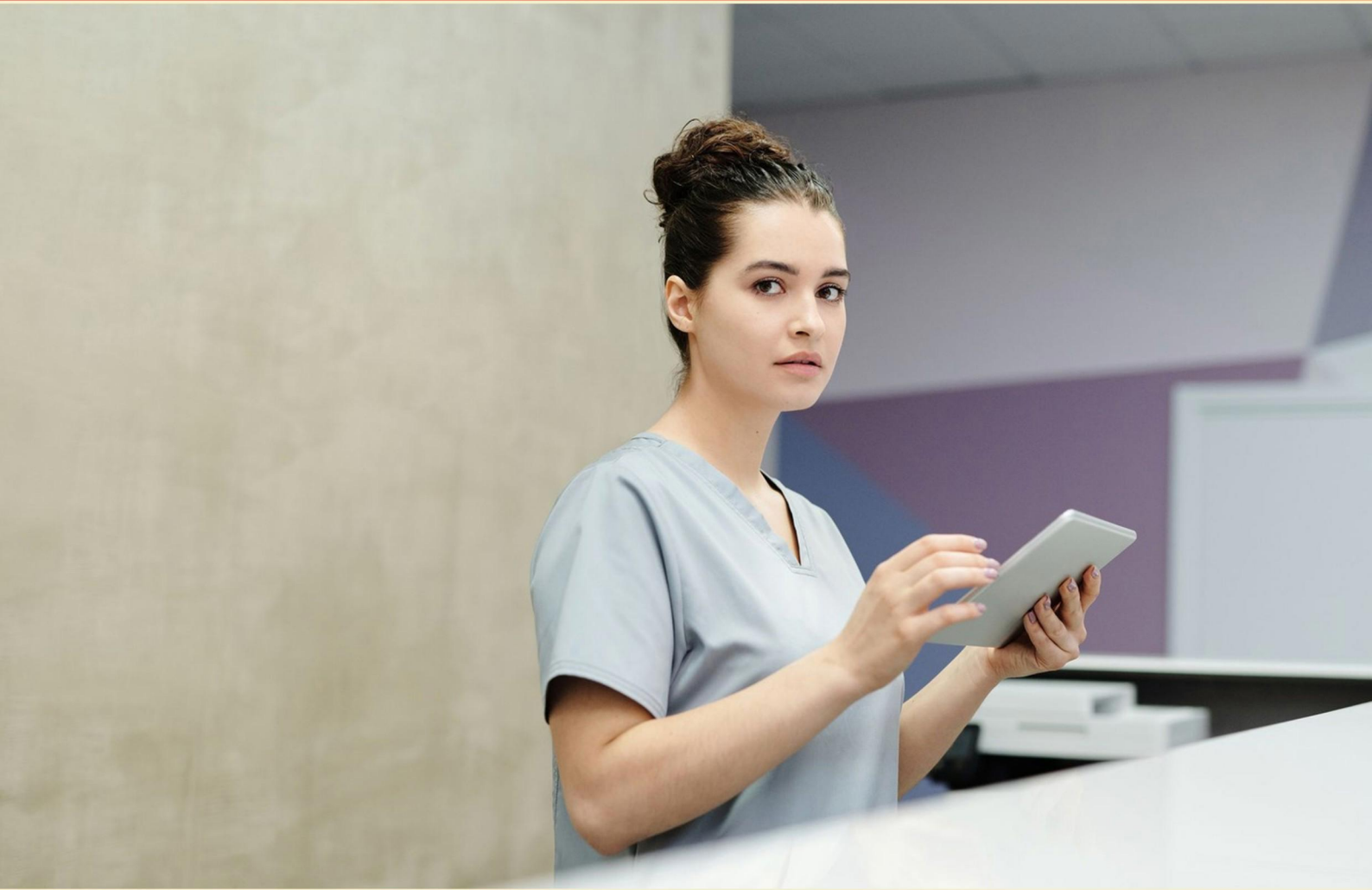


CERTIFIED RELEASE OF INFORMATION SPECIALIST (CRIS) CERTIFICATION PRACTICE TEST (SAMPLE)

STUDY GUIDE



Prepare with structure. Pass with confidence



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Introduction

Preparing for a certification exam can feel overwhelming, but with the right tools, it becomes an opportunity to build confidence, sharpen your skills, and move one step closer to your goals. At Examzify, we believe that effective exam preparation isn't just about memorization, it's about understanding the material, identifying knowledge gaps, and building the test-taking strategies that lead to success.

This guide was designed to help you do exactly that.

Whether you're preparing for a licensing exam, professional certification, or entry-level qualification, this book offers structured practice to reinforce key concepts. You'll find a wide range of multiple-choice questions, each followed by clear explanations to help you understand not just the right answer, but why it's correct.

The content in this guide is based on real-world exam objectives and aligned with the types of questions and topics commonly found on official tests. It's ideal for learners who want to:

- Practice answering questions under realistic conditions,
- Improve accuracy and speed,
- Review explanations to strengthen weak areas, and
- Approach the exam with greater confidence.

We recommend using this book not as a stand-alone study tool, but alongside other resources like flashcards, textbooks, or hands-on training. For best results, we recommend working through each question, reflecting on the explanation provided, and revisiting the topics that challenge you most.

Remember: successful test preparation isn't about getting every question right the first time, it's about learning from your mistakes and improving over time. Stay focused, trust the process, and know that every page you turn brings you closer to success.

Let's begin.

How to Use This Guide

This guide is designed to help you study more effectively and approach your exam with confidence. Whether you're reviewing for the first time or doing a final refresh, here's how to get the most out of your Examzify study guide:

1. Start with a Diagnostic Review

Skim through the questions to get a sense of what you know and what you need to focus on. Your goal is to identify knowledge gaps early.

2. Study in Short, Focused Sessions

Break your study time into manageable blocks (e.g. 30 – 45 minutes). Review a handful of questions, reflect on the explanations.

3. Learn from the Explanations

After answering a question, always read the explanation, even if you got it right. It reinforces key points, corrects misunderstandings, and teaches subtle distinctions between similar answers.

4. Track Your Progress

Use bookmarks or notes (if reading digitally) to mark difficult questions. Revisit these regularly and track improvements over time.

5. Simulate the Real Exam

Once you're comfortable, try taking a full set of questions without pausing. Set a timer and simulate test-day conditions to build confidence and time management skills.

6. Repeat and Review

Don't just study once, repetition builds retention. Re-attempt questions after a few days and revisit explanations to reinforce learning. Pair this guide with other Examzify tools like flashcards, and digital practice tests to strengthen your preparation across formats.

There's no single right way to study, but consistent, thoughtful effort always wins. Use this guide flexibly, adapt the tips above to fit your pace and learning style. You've got this!

Questions

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- 1. What should a health information professional do if asked for medical records without proper authorization?**
 - A. Release the records anyway
 - B. Consult with a supervisor
 - C. Explain the situation to the requester
 - D. None of the above

- 2. The HIPAA Privacy Rule generally treats information about one medical condition the same as information about any other medical condition. Psychotherapy notes are an exception. True or False?**
 - A. True
 - B. False
 - C. Depends on the situation
 - D. Not applicable

- 3. What does the term "release of information" refer to in healthcare?**
 - A. The process of billing patients for services rendered
 - B. The process of providing access to a patient's health information to authorized individuals or entities
 - C. A method for conducting health surveys
 - D. The procedure for ordering medical supplies

- 4. Are disability requests exempt from the HIPAA valid authorization requirements?**
 - A. True
 - B. False

- 5. What type of tests does an Electrocardiogram (EKG) measure?**
 - A. Brain activity
 - B. Heart function
 - C. Lung capacity
 - D. Muscle response

- 6. Which factor may make a request for information incomplete?**
- A. Clear purpose statement provided.
 - B. Missing patient identifiers.
 - C. Signed authorization form.
 - D. Included medical records.
- 7. A person or organization that performs a function or activity on behalf of a covered entity, but is not a part of the covered entity's workforce is called:**
- A. A HIPAA Contingent
 - B. A Business Associate
 - C. A Patient's Advocate
 - D. All of the above
- 8. Which is typically a requirement for a valid medical record disclosure?**
- A. A signed patient authorization
 - B. An internal review
 - C. Only verbal consent
 - D. A legal memorandum
- 9. When dealing with sensitive patient information, what is essential?**
- A. Immediate public disclosure.
 - B. Strict adherence to privacy regulations.
 - C. Exempting minors from protections.
 - D. General sharing without oversight.
- 10. How long must covered entities provide individuals with an accounting of disclosures?**
- A. Three years
 - B. Four years
 - C. Six years
 - D. Indefinitely

Answers

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

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Explanations

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1. What should a health information professional do if asked for medical records without proper authorization?

- A. Release the records anyway
- B. Consult with a supervisor**
- C. Explain the situation to the requester
- D. None of the above

When a health information professional is asked to release medical records without proper authorization, the appropriate course of action is to consult with a supervisor. This is critical, as releasing medical records without proper authorization can violate patient confidentiality and regulatory requirements, such as those set forth by HIPAA (Health Insurance Portability and Accountability Act). A supervisor is typically more experienced in handling such requests and can provide guidance on the correct procedure to follow. They will be able to evaluate the situation, determine if any exceptions apply, and decide on the next steps to ensure compliance with laws and regulations. Consulting a supervisor helps protect the organization and the patient's rights while ensuring that the professional acts within the boundaries of legal and ethical standards. This approach underscores the importance of safeguarding patient information and adhering to established protocols before any action is taken regarding sensitive health data.

2. The HIPAA Privacy Rule generally treats information about one medical condition the same as information about any other medical condition. Psychotherapy notes are an exception. True or False?

- A. True**
- B. False
- C. Depends on the situation
- D. Not applicable

The statement is true because the HIPAA Privacy Rule provides specific protections for psychotherapy notes that are not extended to other types of medical information. While HIPAA encompasses a broad range of health information and generally requires that all healthcare information be treated with confidentiality and respect, psychotherapy notes are considered particularly sensitive. These notes, which contain personal insights, details of patient sessions, and the therapist's observations, are treated differently to safeguard the privacy of the patient. This distinction underlines the importance of protecting mental health records, recognizing that they can contain deeply personal information that may not necessarily be relevant to other medical conditions. The heightened privacy requirement for psychotherapy notes reflects the understanding that mental health information can be particularly vulnerable to stigma and misinterpretation, necessitating additional safeguards. In the context of the other choices, 'False' would imply that psychotherapy notes do not have any special protections which is inaccurate. The option 'Depends on the situation' suggests that there could be circumstances under which psychotherapy notes might not be treated differently, but HIPAA clearly delineates them as exceptions, making this choice incorrect. Finally, 'Not applicable' implies the question or context doesn't apply to HIPAA regulations, which is not the case as the Privacy Rule is precisely about how different types of

3. What does the term "release of information" refer to in healthcare?

- A. The process of billing patients for services rendered
- B. The process of providing access to a patient's health information to authorized individuals or entities**
- C. A method for conducting health surveys
- D. The procedure for ordering medical supplies

The term "release of information" in healthcare specifically refers to the process of providing access to a patient's health information to authorized individuals or entities. This is a critical component of healthcare management and compliance, as it ensures that patient information is shared appropriately while adhering to legal and ethical standards. The release of information facilitates communication among healthcare providers, enables coordination of care, and allows patients to obtain copies of their medical records when needed. This concept is governed by various regulations, including the Health Insurance Portability and Accountability Act (HIPAA), which sets forth guidelines for the protection and sharing of personal health information. The correct understanding of this term is essential for those in the healthcare field, especially for roles focusing on health information management, patient privacy, and compliance with regulations. The other options do not align with the meaning of "release of information." They pertain to distinct processes in healthcare that do not involve the sharing of patient health records or data.

4. Are disability requests exempt from the HIPAA valid authorization requirements?

- A. True
- B. False**

The correct answer is that disability requests are not exempt from the HIPAA valid authorization requirements, which means that a valid authorization is necessary for the disclosure of protected health information (PHI) related to these requests. Under HIPAA, any disclosure of PHI typically requires patient consent unless the information falls into specific categories that allow for disclosure without authorization, such as for treatment, payment, and health care operations. When it comes to disability requests, particularly regarding eligibility for benefits or accommodations, healthcare providers must still adhere to the guidelines set forth by HIPAA. This means that they must secure valid authorization from the individual before sharing their medical information with third parties such as insurance companies or employers. This protects the individual's privacy and maintains the confidentiality of their health information, ensuring that it is disclosed only with proper consent or under specific legal provisions. Understanding this requirement is crucial for professionals in the field, as it reinforces the importance of patient rights and the legal obligations to protect sensitive health information when dealing with disability requests.

5. What type of tests does an Electrocardiogram (EKG) measure?

- A. Brain activity
- B. Heart function**
- C. Lung capacity
- D. Muscle response

An Electrocardiogram (EKG or ECG) measures heart function by recording the electrical activity of the heart over a period of time. This test shows how well the heart is functioning and can help identify various cardiac conditions such as arrhythmias, heart attacks, and other heart diseases. The electrical impulses that trigger heartbeats are captured in the form of waves on a graph, allowing healthcare professionals to assess the heart's rhythm and overall health. In contrast, the other options focus on different bodily systems and processes. For example, brain activity is typically measured using electroencephalograms (EEGs), lung capacity is assessed through pulmonary function tests, and muscle response is often evaluated with electromyography (EMG). Thus, the EKG is specifically designed to provide insights into cardiac health, making "heart function" the accurate choice for what it measures.

6. Which factor may make a request for information incomplete?

- A. Clear purpose statement provided.
- B. Missing patient identifiers.**
- C. Signed authorization form.
- D. Included medical records.

A request for information can be deemed incomplete when there are missing patient identifiers. Patient identifiers, such as the patient's name, date of birth, and other unique identifiers, are essential for accurately locating and releasing the correct information. Without these identifiers, there is a significant risk of misidentifying the patient's records, which could lead to the inappropriate release of information or a delay in the request processing. A clear purpose statement is beneficial as it outlines why the information is being requested but does not in itself render a request incomplete. A signed authorization form is crucial for legal compliance and is a requirement to release information, while included medical records demonstrate that the necessary documents are present. However, without patient identifiers, the request cannot be properly processed, and that makes the request incomplete.

7. A person or organization that performs a function or activity on behalf of a covered entity, but is not a part of the covered entity's workforce is called:

- A. A HIPAA Contingent
- B. A Business Associate**
- C. A Patient's Advocate
- D. All of the above

The correct answer is "A Business Associate." In the context of HIPAA (Health Insurance Portability and Accountability Act), a business associate is defined as a person or entity that performs certain functions or activities on behalf of a covered entity that involves the use or disclosure of protected health information (PHI). This can include services such as data analysis, billing, or IT support. The significance of the business associate designation lies in the requirement that these parties must adhere to specific safeguards for protecting PHI, as outlined in the business associate agreement. This agreement is a legal document that establishes the permitted uses and disclosures of PHI by the business associate and ensures compliance with HIPAA regulations. Understanding this distinction is essential in the field of health information management, as it helps maintain the privacy and security of sensitive health data while allowing covered entities to utilize external resources. This framework is critically important to ensure that patient information is shared appropriately and responsibly, thereby safeguarding patient rights and enhancing trust in healthcare systems.

8. Which is typically a requirement for a valid medical record disclosure?

A. A signed patient authorization

B. An internal review

C. Only verbal consent

D. A legal memorandum

A signed patient authorization is typically a requirement for a valid medical record disclosure because it is the legal documentation that grants permission for healthcare providers to share patient information with third parties. This requirement ensures that the patient's privacy rights are upheld and that they have control over their own medical information. The signed authorization must generally include specific information, such as what information is to be disclosed, to whom it is being disclosed, and the purpose of the disclosure, helping to maintain compliance with laws like HIPAA (Health Insurance Portability and Accountability Act) in the United States. In contrast to this, other options like an internal review, verbal consent, or a legal memorandum do not suffice as standalone requirements for the disclosure of medical records. An internal review may be conducted for quality assurance or administrative purposes but does not constitute patient consent. Verbal consent, while sometimes acceptable in certain situations, is often not considered sufficient on its own for disclosure of medical records, especially where documentation of consent is mandated. Lastly, a legal memorandum is typically a document used for legal purposes and does not serve as a means of patient authorization for record disclosure.

9. When dealing with sensitive patient information, what is essential?

A. Immediate public disclosure.

B. Strict adherence to privacy regulations.

C. Exempting minors from protections.

D. General sharing without oversight.

Strict adherence to privacy regulations is essential when dealing with sensitive patient information because these regulations are designed to protect patient confidentiality and ensure that personal health data is handled responsibly. Compliance with laws such as the Health Insurance Portability and Accountability Act (HIPAA) in the United States is crucial to safeguarding patient information from unauthorized access and misuse. These regulations establish standards for the protection of health information, outlining the rights of patients and the responsibilities of healthcare providers and organizations in managing that data. Maintaining confidentiality not only helps build trust between patients and healthcare providers but also minimizes the risk of data breaches and legal consequences that can arise from noncompliance. Privacy regulations also stress the importance of informed consent, allowing patients to know how their information will be used and shared, further reinforcing the need for adherence to these guidelines.

10. How long must covered entities provide individuals with an accounting of disclosures?

- A. Three years
- B. Four years
- C. Six years**
- D. Indefinitely

Covered entities are required to provide individuals with an accounting of disclosures of their protected health information (PHI) for a period of six years prior to the request. This requirement is outlined in the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. The accounting of disclosures must include all disclosures made for purposes other than treatment, payment, and health care operations. The six-year timeframe allows individuals to understand how their information has been shared and to whom it has been disclosed, which is an important aspect of promoting transparency and trust in the management of personal health information. This period ensures that individuals have access to pertinent information about the handling of their PHI, while balancing the administrative burden on the covered entities involved. In contrast, the other options incorrectly suggest longer or shorter timeframes for the requirement, which do not align with HIPAA guidelines. Understanding this timeframe is crucial for compliance with HIPAA and for ensuring that individuals' rights concerning their health information are protected.

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Next Steps

Congratulations on reaching the final section of this guide. You've taken a meaningful step toward passing your certification exam and advancing your career.

As you continue preparing, remember that consistent practice, review, and self-reflection are key to success. Make time to revisit difficult topics, simulate exam conditions, and track your progress along the way.

If you need help, have suggestions, or want to share feedback, we'd love to hear from you. Reach out to our team at hello@examzify.com.

Or visit your dedicated course page for more study tools and resources:

<https://certreleaseofinfospecialist.examzify.com>

We wish you the very best on your exam journey. You've got this!

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