CATALYST
Medical Center + Clinical Spa

MEDICAL FORM

Authorization for Release of Medical Information

Patient Name: _____ **Date Of Birth:** ____/____/____

Address: _____

City/State/Zip: _____

I authorize Catalyst Medical Center and Clinical Spa to:

☐ **Send** copies of your record to (or discuss information with) the provider/person/facility below:

OR

☐ **Receive** copies of your medical record from (or discuss information with) the provider/person/facility below:

Name of provider/person/facility: _____

Address: _____ **Phone:** _____

City/State/Zip: _____ **Fax No:** _____

☐ **Progress Notes** ☐ **Operative Notes** ☐ **Cosmetic Notes** ☐ **Pathology/Lab Reports**

☐ **Audio Reports** ☐ **Allergy Reports** ☐ **ENT Reports** ☐ **Dermatology Reports**

☐ **Diagnostic Imaging** ☐ **Entire Medical Record** ☐ **State Other Records:** _____

_____

Restrictions: *Only medical records originating through Catalyst MC + CS will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified. The records above may be faxed in case of medical necessity. This authorization may be canceled at any time by submitting a written request to Catalyst MC + CS. This authorization will remain in effect until we have written notice of cancellation.*

I have read the above Authorization for Release of Medical Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

Patient/Representative Signature: _____ **Date:** ____/____/____

Relationship to Patient (if other than self): _____

Printed Name of Representative: _____