CATALYST
Medical Center

Authorization for Release of Medical Information Form

Full Name : _____ **Date of Birth:** ____/____/____

Address : _____

City/State/Zip: _____

I authorize Catalyst Medical Center + Clinical Spa to:

☐ Send copies of, or discuss, your medical records with the provider, person, or facility below:

☐ Receive copies of, or discuss, your medical records with the provider, person, or facility below:

Name provider, person or facility: _____

Address : _____ **Phone:** _____

City/State/Zip: _____ **Fax:** _____

☐ Allergy Reports ☐ Pathology/ Lab Reports ☐ Dermatology Reports ☐ ENT Reports ☐ Audio Reports ☐ Operative Notes ☐ Progress Notes

☐ Cosmetic Notes ☐ Diagnostic Imaging ☐ Entire Medical Record ☐ Specify Other Records: _____

Restrictions: This authorization applies only to the records specified above and may be revoked at any time by submitting a written request, except to the extent action has already been taken. Unless otherwise indicated, this authorization expires one year from the date of signature. Information disclosed may be subject to redisclosure by the recipient and may no longer be protected under federal privacy regulations.

REASON FOR RELEASE

☐ Personal Use ☐ Insurance Purposes ☐ Continuing Care (Another Healthcare Provider/Facility) ☐ Legal Purposes ☐ Other Reason: _____

Important Notice: There is no charge for providing a copy of a patient's health care records to another healthcare provider for the purpose of continuing treatment. Pursuant to North Dakota Century Code § 23-12-14 and applicable federal law, all other record requests may be subject to reasonable, cost-based fees. Current fee schedules are available upon request.

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 Signee: _____