Authorization for Release of Medical Information

CATALYST
Medical Center + Clinical Spa

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

Address:_____ **City/State/Zip:**_____

Treatment, Payment, and Health Care Operations (TPO)
Catalyst Medical Center + Clinical Spa may use or disclose your protected health information **without your written authorization** for purposes of **treatment, payment, and health care operations (TPO)** as permitted by federal and state law. These uses and disclosures are described in our **Notice of Privacy Practices**.
This authorization applies only to disclosures that are **not otherwise permitted** for treatment, payment, or health care operations.

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 of Provider/Person/Facility: _____ **Phone:**_____

Address: _____ **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, Expiration, and Revocation
This authorization applies only to the medical records specified above. I understand that:

- I may revoke this authorization at any time by submitting a written request, except to the extent action has already been taken in reliance on this authorization.
- Unless otherwise indicated, this authorization expires one (1) year from the date of signature.
- Information disclosed pursuant to this authorization 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 ☐ Legal Purposes
☐ Other Reasons: _____

Important Notices

- I understand that signing this authorization is voluntary.
- I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on signing this authorization.
- There is no charge for providing copies of medical records to another health care provider for purposes of continuing treatment. Pursuant to North Dakota Century Code § 23-12-14 and applicable federal law, other record requests may be subject to reasonable, cost-based fees. Current fee schedules are available upon request.

Acknowledgment and Signature
I have read and understand this Authorization for Release of Medical Information and agree to the terms described above.

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

Relationship to Patient (if other than self): _____

701.365.8700 wecare@catalystmedicalcenter.com 1800 21St Ave S, Fargo, ND 701.365.8701