1800 21st Avenue South
Fargo, ND 58103
T: 701-365-8700
F: 701-365-8701

Catalyst
MEDICAL CENTER & CLINICAL SPA

STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Information to be Used or Disclosed
The information covered by this authorization includes:
_____
_____
_____

Persons Authorized to Use or Disclose information
Information listed above will be used or disclosed by:
_____
Name of person or organization
_____
Address or person or organization (including fax number)

Persons to Whom Information May Be Disclosed
Information described above may be disclosed to:
CATALYST MEDICAL CENTER
Name of person or organization
1800 21st Avenue South Fargo, ND 58103 Fax 701/365-8701 .
Address of person or organization (including fax number)

Expiration Date of Authorization
This authorization is effective through _____ / _____ / _____ unless revoked or terminated by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to Catalyst Medical Center. You should contact our Billing Manager / Compliance Officer, to terminate this authorization.

Potential for Re-disclosure
Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits except as permitted by law.

Signature
_____
Name of Patient (print or type) Date of Birth
_____
Signature of Patient Date
_____
Signature of Patient Representative (including relationship) Date
_____