

1800 21st Avenue South
Fargo, ND 58103
T: 701.365.8700
F: 701.365.8701



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 Cindy Willows-Murdock, 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

Witness

Date