CATALYST
Medical Clinic PA

Medical Information Release Form
(HIPAA Release Form)

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

RELEASE OF INFORMATION

- ☐ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:
  - Spouse:_____
  - Child(ren):_____
  - Parent/Legal Guardian(s):_____
  - Other:_____
- ☐ Information is not to be released to anyone.

MESSAGES

Please call: Cell Work Home Phone Number:_____

If unable to reach me:

- ☐ You may leave a detailed message
- ☐ Please leave a message asking me to return your call
- ☐ Other:_____

Authorization/Revocation:

- Authorization lasts for 1 year after the date you sign it unless you enter a different date or expiration:_____
- Authorization may be canceled in writing at any time. Once the health information has been released to another facility or provider, there is no way to cancel or stop the release.
- A photocopy of this authorization is as valid as the original.
- Catalyst Medical Clinic, PA (CMC) cannot prevent redisclosure of your information by the person or organization who receives your records under this authorization, and that information may not be covered by state and federal privacy protections after it is released. By signing this authorization, you release CMC from any and all liability resulting from a redisclosure by the recipient.
- Your signature indicates that you have read and understand this form.

Signature: _____ Date: _____

If signing for a minor patient: _____

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