CATALYST
Medical Clinic PA

AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT INFORMATION:	Name: _____ Date of Birth: _____ Social Sec. #: (Optional)_____ Phone #: _____
Health Information Released FROM:	○ Catalyst Medical Clinic, PA ____Watertown _____ Chaska ○ OTHER: Person/Organization:_____ Street Address:_____ City/State/Zip: _____ Phone: _____ Fax: _____
Health Information Released TO:	○ Catalyst Medical Clinic, PA ____Watertown _____ Chaska ○ Other: Person/Organization: _____ Street Address: _____ City/State/Zip:_____ Phone: _____ Fax: _____
Specific Information to be Disclosed:	**Most Recent:** _____ History & Physical _____ Lab _____ Last 2 office visits _____ Immunizations _____ Mental Health summary **Last 12 months:** _____ EKG report _____ MRI Report _____ CT Report _____ X-Ray Report _____ Other **Dates of Service:** _____ Office visits _____ History & Physical _____ Lab _____ Diagnostic _____ Other
Purpose of Release:	_____ Payment of Claim _____ Continued Medical Care _____ Mental Health _____ Work Comp/Ins. _____ Transfer of Care _____ Other **There may be a charge/fee for copies of records**
Release Instructions:	_____ Fax ____ Mail ____ Pick up by patient (requires photo ID) Date information is needed: _____ (NOTE: Please allow 7-10 days for processing)
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: _____
STAFF USE ONLY	Information released by:_____ Date:_____ Form of ID: _____

Catalyst Medical Clinic, PA
204 Lewis Ave S, Suite 201
Watertown MN 55388
PH: 952-955-1963 FAX: 952-955-1965

Catalyst Medical Clinic, PA
1200 Chaska Creek Way, Suite 200
Chaska MN 55318
PH: 952-856-1046 FAX: 952-856-1049