HIPAA Authorization for Use or Disclosure of Health Information

Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information and when we need your written authorization to do so. This form is for use when such authorization is required.

Name of Patient:____

Date of Birth: ____

Catalyst Sports Medicine may disclose the following information to the following individuals:

Name:____

Relationship to patient:____

Information to be disclosed:

____ Health information

____ Billing and account information

Name:____

Relationship to patient:____

Information to be disclosed:

____ Health information

____ Billing and account information

Name:____

Relationship to patient:____

Information to be disclosed:

____ Health information

____ Billing and account information

PATIENT SIGNATURE______________________________________**DATE:**_______________

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