KAISER PERMANENTE®

Kaiser Foundation Hospitals
Permanente Medical Groups

AUTHORIZATION FOR USE OR DISCLOSURE OF PATIENT HEALTH INFORMATION

Note: Fees may apply to certain requests

Patient Name: _____
Kaiser # _____ Date of Birth: _____
Address: _____
City: _____
State: _____ Zip Code: _____
Telephone Number: ( ) _____
Email: _____

Kaiser Permanente will not condition treatment, payment, enrollment or eligibility for benefits on providing, or refusing to provide this authorization.

This authorizes the following Kaiser Permanente Medical Center(s): _____

To:
- ❑ Produce a copy of medical records as specified below
- ❑ Complete form(s) (Please specify form type(s) in the PURPOSE section below)
- ❑ Allow named KP physician to view records

Kaiser Permanente may disclose this information to:

Recipient Name: _____
Address: _____
City: _____
State: _____ Zip Code: _____
Telephone number: ( ) _____
Fax number: ( ) _____
Email: _____

PURPOSE: The health information disclosed may only be used for the following purposes: _____

FOR COPIES, SPECIFY THE HEALTH INFORMATION NEEDED FOR USE OR DISCLOSURE

- ❑ Medical Office Records dated from _____ to _____
- ❑ Hospital Records dated from _____ to _____

NOTE: Hospital and medical office records may include information related to mental health, alcohol/drug, and HIV references. The actual treatment records from mental health and/or alcohol/drug departments, and/or results of HIV tests will not be disclosed unless specifically requested below.

SIGNATURES AND DATES REQUIRED IF ANY OF THE FOLLOWING BOXES ARE CHECKED

- ❑ Mental Health dated from _____ to _____ Signature: _____ Date: _____
- ❑ Alcohol / Drug dated from _____ to _____ Signature: _____ Date: _____
- ❑ HIV Test Results dated from _____ to _____ Signature: _____ Date: _____

- ❑ Specific Injury/Treatment: _____ Department: _____ dated from _____ to _____
- ❑ X-Ray: ❑ Images and/or Films ❑ Reports Describe: _____
- ❑ Laboratory Results dated from _____ to _____
- ❑ Other (specify): _____
- ❑ Protected Minor Records (Adolescent Confidential). Only applicable for patient requesters 12-17 years old.

Media Preference: ❑Paper ❑CD (if available electronically) **Delivery Preference:** ❑Mail ❑Pickup ❑Fax ❑Email

DURATION: This authorization shall remain in effect for one year from the date of signature unless a different date is specified here _____(date).

REVOCATION: You or your representative can revoke this authorization upon written request. If you revoke, it will not affect information disclosed before the receipt of the written request.

REDISCLOSURE: Once this health information is disclosed, how the recipient further discloses it may no longer be protected under federal privacy law (HIPAA).

A copy of this authorization is as valid as an original. I have the right to receive a copy of this authorization.

Date _____ Signature _____ If not patient, print your name and relationship _____