



KAISER PERMANENTE®

Kaiser Permanente Insurance Company

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: _____

Providers named herein will not condition treatment, payment, enrollment or eligibility for benefits on providing, or refusing to provide this authorization.

This authorizes the following Providers including 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 physician to view records

Provider(s) 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).

REVOCAATION: 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.

REDISCLASURE: 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