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 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.

SIGNATURE 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: _____

☐ Specify 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 _____

MUST FILL IN ALL RED AREAS, REFER TO BLUE/GREEN AREAS FOR SPECIFIC REQUEST

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AUTHORIZATION FOR USE OR DISCLOSURE OF PATIENT HEALTH INFORMATION

Note: Fees may apply to certain requests

(#1) Patient Name: Patients First & Last name
Kaiser # Kaiser card # Date of Birth: Birthday
Address: Patients Full address needed
City: _____
State: _____ Zip Code: _____
Telephone Number: ( ) Must provide phone #
Email: Patients personal email address

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

(#2) **This authorizes the following Kaiser Permanente Medical Center(s):** what locations have you been seen at

(#3) To: CHECK ONLY ONE BOX
- ☐ Produce a copy of medical records as specified below — ALL GREEN AREAS
- ☐ Complete form(s) (Please specify form type(s) in the PURPOSE section below) * Check this box for form or letter, fill in all red areas
- ☐ Allow named KP physician to view records

(#4) **Kaiser Permanente may disclose this information to:**
Recipient Name: Who is receiving information
Address: Receiver's Full address needed
City: _____
State: _____ Zip Code: _____
Telephone number: ( ) Phone # needed
Fax number: ( )
Email: Receiver's email address

(#5) PURPOSE: The health information disclosed may only be used for the following purposes: _____
Why Information is Needed

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

(#6)
- ☐ Medical Office Records dated from _____ to _____
- ☐ Hospital Records dated from _____ to _____

Fill in only if Requesting Copy of Records

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.

(#7) **SIGNATURES AND DATES REQUIRED IF ANY OF THE FOLLOWING BOXES ARE CHECKED**
- ☐ Mental Health dated from _____ to _____ Signature: MUST SIGN HERE IF INFORMATION REQUESTED PERTAINS TO MENTAL HEALTH Date: Today's Date
- ☐ Alcohol / Drug dated from _____ to _____ Signature: _____ Date: _____
- ☐ HIV Test Results dated from _____ to _____ Signature: _____ Date: _____

(#8)
- ☒ Specific Injury/Treatment: Body part/ condition Department: _____ dated from time frame 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.

(#9) **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.

(#10) Today's Date — Date
Patients Signature — Signature
Must provide POA if not patient or parent — If not patient, print your name and relationship

NS-9934 (2-11) HIPAA COMPLIANT SPANISH-NS-1614; CHINESE-NS-6274
90258 (REV. 2-11) SPANISH 01782-000; CHINESE 01782-002

ORIGINAL - DISCLOSING PARTY CANARY - PATIENT