KAISER PERMANENTE

Kaiser Foundation Health Plan of the Northwest • Kaiser Foundation Hospitals

Authorization for Kaiser Permanente to Release Medical Information

PATIENT		
NICKNAME / MAIDEN NAME / OTHER	SOCIAL SECURITY	
HEALTH RECORD NO.		
DATE OF BIRTH: (MO/DAY/YR)	PHONE NUMBER ( )	
ADDRESS	STREET OR BX NUMBER	
CITY	STATE	ZIP + 4

I authorize Kaiser Permanente to release the following information for the purpose of: _____

_____

- ❑ All pertinent medical records
- ❑ Mental Health information
- ❑ X-ray films (describe): _____
- ❑ Specific information as indicated: _____

_____

Please send my medical information to:

_____
NAME OF PERSON TO RECEIVE INFORMATION

_____
TITLE (PHYSICIAN, ATTORNEY, ETC.) PHONE NUMBER

_____
STREET ADDRESS

_____
CITY, STATE, ZIP CODE

X _____
SIGNATURE OF PERSON AUTHORIZING RELEASE OF INFORMATION

X _____
SIGNATURE OF PARENT OR LEGAL GUARDIAN IF APPLICABLE

_____
DATE

I recognize that the information released may contain drug/alcohol information that is protected by federal and state law. (42CFR2.31) I specifically consent to its release.

X _____
SIGNATURE

X _____
DATE

I recognize that the information released may contain information regarding HIV/AIDS testing, treatment, or high risk behavior. (ORS423.045(3) and OAR33312270) I specifically consent to its release.

X _____
SIGNATURE

X _____
DATE

I recognize that the information released may contain genetic information that is protected by state law. (ORS659.710) I specifically consent to its release.

X _____
SIGNATURE

X _____
DATE

Definitions for Release of Genetic Information:

Genetic Information: is information about an individual or family obtained from: (1) a genetic test, or (2) an individual's DNA sample.

Genetic Characteristic: Means any gene or chromosome, or alteration thereof, that is scientifically or medically believed to cause a disease, disorder or syndrome, or to be associated with statistically increased risk of development of a disease, disorder or syndrome.

Genetic Test: means a test for determining the presence or absence of genetic characteristics in an individual, including tests of nucleic acids such as DNA, RNA and mitochondrial DNA, chromosomes or proteins in order to diagnose a genetic characteristic.

My consent may be revoked at any time. The only exception is when the action has already occurred as instructed in the consent. In Oregon, unless revoked earlier, this consent will expire in 4 months from the date of signing or shall remain in effect for the period reasonably needed to complete the request. In Washington, this consent will expire in 90 days.

ASSIGNMENT OF BENEFITS: FOR USE BY INSURANCE CLAIMS DEPARTMENT ONLY

My signature below authorizes payment by my insurer to the physician/hospital on benefits payable to me but not to exceed the balance of my account.

Signature: X _____ Date: X _____