KAISER PERMANENTE®

**Stapleton Support Services**
11000 E. 45th Avenue, Denver, CO 80239-3004
TTY: 1-800-659-2656

# Authorization to Use and/or Disclose Protected Health Information

| | | | | |
|---|---|---|---|---|
| **Forms Processing** | • | Phone: 303-404-4600 | • | Fax: 303-404-4650 |
| **Release of Information** | • | Phone: 303-404-4700 | • | Fax: 303-404-4750 |

**I authorize Kaiser Foundation Health Plan of Colorado (KFHP) and/or the Colorado Permanente Medical Group (CPMG) to release the health information of the individual named below:**

Patient Name _____ Medical Record Number _____

Street Address _____ City _____ State _____ ZIP _____

Phone number _____ Date of birth _____

**I authorize the information to be disclosed to and used by the following individual or organization:**

Name of receiving party or organization _____

☐ Pick up in person
☐ Fax (for forms processing only)
☐ Mail

Street address _____ City _____ State _____ ZIP _____

Phone number _____ Fax number _____

**Purpose of Use or Disclosure**

☐ FMLA/LOA ☐ Narrative ☐ Employer Request ☐ Personal Use ☐ Continuity of Care
☐ Return to Work ☐ Insurance ☐ Social Security ☐ Attorney ☐ Workers Compensation
☐ Other (Specify): _____

**The type and amount of information to be disclosed is as follows (specify dates):**

☐ Immunizations
☐ Most recent _____ (years) of record
☐ Entire medical record
☐ FMLA/Return to work paperwork
☐ Other (Specify): _____

☐ Laboratory Results: __/__/____ to __/__/____
☐ X-Ray Reports: __/__/____ to __/__/____
☐ Genetic testing: __/__/____ to __/__/____
☐ HIV/AIDS information: __/__/____ to __/__/____

I am requesting that Kaiser Permanente release these records in the following format:

☐ Paper format ☐ Electronic format (<u>only</u> applies to records maintained by Kaiser Permanente in an electronic medical record)

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Patient Name (please print) _____ Medical Record Number _____

- I understand that the medical information released by this authorization may include information concerning treatment of physical or mental illness, alcohol/drug abuse, and past medical history.
- I understand this authorization will expire, without my expressed revocation, either one year from the date of signing, or the date the minor child becomes an adult according to state law, whichever occurs first. I understand that I may revoke this authorization by sending a request in writing to the address at the top of this form, except to the extent that action has been taken based on it. I understand that revocation will not apply to information that has already been released as specific by this authorization or to my insurance company when the law provides my insurer with the right to contest a claim under my policy or the policy itself.
- I understand that Kaiser Permanente will only release requested records up to the date of my signature, and does not include future records. If I request to have records disclosed in the future, I will be required to complete a new authorization.
- I understand that authorization for the disclosure of this health information is voluntary and I can refuse to sign this authorization. KFHP/CPMG cannot condition treatment, payment, or enrollment in the health plan or eligibility for benefits on the signing of an authorization, except as otherwise permitted by law. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure by the receiving party, which may not be protected by federal confidentiality rules.

➡ _____ _____
Signature of Patient or Authorized Personal Representative Date

_____
Personal Representative's Name and Relationship *(please attach applicable legal documentation of authority)*

**Fees/Financial responsibility:**

Paper Format:

- Per Colorado Department of Public Health and Environment (CDPHE) regulations, the fee for copying requested documents is $14.00 for the first ten pages, $.50 per page for pages 11 through 40, and $.33 per page for each page over 40. Shipping and applicable sales tax will also be charged.
- There is no charge for records sent from Kaiser Permanente to another health care provider for treatment purposes.

Electronic Format:

- The fee for electronic copies of medical records is $14.00.

I accept full financial responsibility for copying fees. Failure to sign this section may result in Kaiser Permanente not releasing your medical records in response to this request.

➡ _____ _____
Signature of Patient or Authorized Personal Representative Date

**For Kaiser Permanente Office Use Only:** Verification of Photo Identification

ID# and State _____ Verified by:_____