KAISER PERMANENTE® **HAWAII REGION**

Authorization for Release of Protected Health Information

MR #: UC Loc:

Name:

Sex/BD:

Original: 7/1/98 Revised: 5/8/03 Reviewed:

1. *Date Format: MM / DD / YYYY*

I hereby authorize:

Sender or institution: _____

Address: _____

City: _____ State: _____ Zip Code: _____

2. **Release to:**

A. ☐ Patient or Authorized Representative

B. ☐ Kaiser Permanente Medical Center: 3288 Moanalua Road, Honolulu, Hawaii, 96819:

Attention Outpatient Medical Records for: _____

➲ Upon receipt, forward to requester *Physician • Department • Location*

C. ☐ Physician, receiving person, agency or institution: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Attention: _____ Dept: _____

3. *Pertaining to the care of:*

Name: Last _____ First _____ M.I. _____

MR #: _____ and SS #: _____

Also known as: _____ Birthdate : ____ ____ _____

4. *For the purpose of:* _____

5. *Description of Information:*

Disclosure is authorized for any and all information about medical history, mental and physical condition, including HIV infection, AIDs, or ARC, drug and alcohol use, and other personal information unless otherwise specified.

6. *Fees:*

A reasonable fee will be charged for duplication of records. An estimate of those charges will be provided upon request prior to duplication.

7. *Duration of validity:*

This authorization is valid for six (6) months from the date of signing unless revoked in writing by the undersigned prior to six (6) months. The undersigned may revoke this by submitting a letter to Health Information Management Department at 3288 Moanalua Road, Honolulu, Hawaii 96819. I understand that the revocation will not apply to any action taken in reliance on this authorization.

8. *Re-disclosure:*

The information used and/or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by 45 CFR Subtitle A, Subchapter C, Section 164.508.

9. *Signature:*

I understand that Kaiser Permanente may not condition treatment, payment, enrollment in the health plan, or eligibility for benefits on my execution of this authorization, except when Kaiser Permanente seeks authorization (1) because it is providing research-related treatment; (2) for purposes of determining health plan eligibility, enrollment underwriting, or risk rating, so long as the authorization is not for use or disclosure of HIPAA psychotherapy notes; or (3) because it is providing treatment solely for the purpose of creating protected health information for disclosure to a third party.

Date: ____ ____ _____ Signature: _____ Ph # ____ - _____

Patient • Authorized Representative

If signed by other than patient or parent of minor child, please print name and indicate relationship. Submit documents to show authority to request information on the patient.

Print: _____ _____

Authorized representative's name *Relationship to patient*

Please return a copy of this authorization form with your report. Thank You!