



Kaiser Foundation Health Plan of the Northwest • Kaiser Foundation Hospitals
Kaiser Permanente Health Alternatives

Authorization for Kaiser Permanente to Use/Disclose Protected Health Information

1 MEMBER MUST COMPLETE THIS SECTION

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

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

3 _____
NAME OF PERSON TO RECEIVE INFORMATION

TITLE (PHYSICIAN, ATTORNEY, ETC.) PHONE NUMBER

STREET ADDRESS CITY STATE ZIP CODE

4 The purpose or need for the exchange and disclosure of this information is to:

- Facilitate treatment;
- Summarize treatment and/or;
- Facilitate billing/reimbursement from insurance carriers.

Description of information to be used/disclosed (Be as specific as possible):

- 5
- All records
 - X-ray films (describe): _____
 - Other (describe): _____

If the information to be used/disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be used or disclosed if I **place my initials** in the applicable space next to the type of information:

- 6
- _____ Drug/Alcohol diagnosis, treatment or referral information
 - _____ Mental Health information – including provider notes
 - _____ HIV/AIDS information
 - _____ Genetic testing information

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of drug/alcohol diagnosis, treatment or referral information, mental health information and genetic testing information.

You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care service is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any use or disclosure already made with your permission cannot be undone. To revoke this authorization, please send a written statement to Kaiser Permanente, Release of Information Department at 10220 SE Sunnyside Rd., Clackamas, Oregon 97015 and state that you are revoking this authorization. To revoke this authorization orally, please call Release of Information Department at 503-571-5051 and state that you are orally revoking this authorization.

I have read this authorization and understand it. Unless revoked, this authorization expires in 12 months. In Washington, this authorization shall expire 90 days after the date signed if disclosure is to a financial institution or an employer for purposes other than payment.

7 X _____
SIGNATURE OF INDIVIDUAL OR PERSONAL REPRESENTATIVE

8 X _____
DATE

X _____
DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY

SEE REVERSE SIDE FOR MAILING INSTRUCTIONS

AUTHORIZATION FOR KAISER PERMANENTE TO RELEASE MEDICAL INFORMATION

Instructions

How to fill out “Authorization for Kaiser Permanente to Use/Disclose Protected Health Information” form

- ① Member must complete this section. If not complete, form may be sent back to you.
Complete each box as indicated with the following information:
 - Patient’s Name (Print clearly)
 - Other names the patient has used. If none, leave this box blank
 - Health Record Number
 - Date of Birth
 - Telephone Number where you can be reached during the day
 - Home Street Address
 - Home City, State and Zip Code

- ② State the purpose for the release of information. Examples: Insurance application, Insurance Claim, Legal, Benefits, School, Patient Care, etc. (*For my own purposes* may be used only if you are releasing records to yourself)

- ③ Write the name or company of who is to receive the information. Include:
 - Name or Company
 - Title of who is to receive the information. Examples: Attorney, Physician, etc.
 - Telephone of the person or company who will receive the information
 - Street address of who will receive the information
 - City, State and Zip Code of who will receive the information

- ④ Check the box(es) that apply to the purpose or need for the exchange and disclosure of this information.

- ⑤ Check the box(es) that apply to your request:
 - Checking All Records will allow the release of any records needed to respond to your request unless there is sensitive information (see ⑥).
 - By checking Other you will need to describe exactly what you want released. Examples: All records regarding my back injury, or All information needed to complete the attached form, etc.
 - Check X-ray films only if you want the actual films to be released.

- ⑥ INITIAL for any sensitive information protected by law you want to be released.

- ⑦ Sign the authorization. If you are not the patient, describe your relationship and legal authority to sign. You will be required to provide the legal paperwork.

- ⑧ Date the authorization.