KAISER PERMANENTE®

Patient Name: _____

Medical Record Number: _____

Birth Date: _____ Email: _____

Do not use for patient copies of or access to their medical records. Patients should go to kp.org/requestrecords to conveniently request medical records, FMLA and Disability certifications.

AUTHORIZATION FOR USE OR DISCLOSURE OF PATIENT HEALTH INFORMATION
To the Following Third-Party Recipient (Fees may be required)

Recipient Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone # (_____) _____ Email: _____

This disclosure can be used for the following purpose(s): ❑ Legal ❑ Insurance ❑ Medical Certification ❑ Other

Hospital and Medical Office records released as part of this authorization may contain references related to mental health, addiction, and HIV medical conditions documented by primary care.

I authorize the following to be disclosed for the selected time frame:

❑ Form Completion (a substitute form or relevant medical records may be released in lieu) ❑ Medical Records
❑ Diagnostic Images ❑ Itemized Billing Records ❑ Pharmacy Copays ❑ Medical Copays
Time Frame: Last ❑ 2 months ❑ 6 months ❑ 1 year ❑ 2 years ❑ 5 years ❑ All electronic records

Check the boxes below if you want this release to include the protected treating department or HIV initial test result information. If not checked, this treating department information will be excluded.

❑ Mental Health Treatment Records ❑ Addiction Medicine Treatment Records ❑ HIV Lab Test Results
Kaiser Permanente Oregon locations need to **also** check this box if they want Genetic Testing information released. ❑

DURATION: Authorization shall remain in effect for 6 months from the date of signature below.

REVOCATION: You or your personal representative may cancel this authorization for future releases by submitting a written request to the Release of Information Unit listed for your region of service found on kp.org/requestrecords. Your cancellation will not affect information that was released prior to receipt of the written request.

REDISCLOSURE: Once this information is released, it may not be protected under federal privacy law (HIPAA). State or other federal law may require the recipient to obtain your authorization before further disclosure.

Kaiser Permanente may not condition treatment, payment, enrollment, or eligibility for benefits on whether you sign this authorization. This disclosure is made at your request. For Virginia patients, a copy of this authorization, and a note stating to whom your information was disclosed will be included in your medical record. A copy of the original authorization is valid. You have a right to a copy of this completed authorization.

We will provide the requested information in electronic format to the recipient unless the recipient contact us to make other arrangements.

_____ _____ _____

Date Signature If personal representative, print name/relationship