



Kaiser Foundation Hospitals  
Permanente Medical Groups

### AUTHORIZATION FOR USE OR DISCLOSURE OF PATIENT HEALTH INFORMATION

Note: Fees may apply to certain requests

Patient Name: \_\_\_\_\_  
 Kaiser # \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_  
 State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Telephone Number: (\_\_\_\_) \_\_\_\_\_  
 Email: \_\_\_\_\_

**Kaiser Permanente will not condition treatment, payment, enrollment or eligibility for benefits on providing, or refusing to provide this authorization.**

This authorizes the following Kaiser Permanente Medical Center(s): \_\_\_\_\_

- To:  Produce a copy of medical records as specified below
- Complete form(s) (Please specify form type(s) in the PURPOSE section below)
- Allow named KP physician to view records

Kaiser Permanente may disclose this information to:

Recipient Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_  
 State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Telephone number: (\_\_\_\_) \_\_\_\_\_  
 Fax number: (\_\_\_\_) \_\_\_\_\_  
 Email: \_\_\_\_\_

PURPOSE: The health information disclosed may only be used for the following purposes: \_\_\_\_\_

### FOR COPIES, SPECIFY THE HEALTH INFORMATION NEEDED FOR USE OR DISCLOSURE

- Medical Office Records dated from \_\_\_\_\_ to \_\_\_\_\_
- Hospital Records dated from \_\_\_\_\_ to \_\_\_\_\_

**NOTE: Hospital and medical office records may include information related to mental health, alcohol/drug, and HIV references. The actual treatment records from mental health and/or alcohol/drug departments, and/or results of HIV tests will not be disclosed unless specifically requested below.**

### SIGNATURES AND DATES REQUIRED IF ANY OF THE FOLLOWING BOXES ARE CHECKED

- Mental Health dated from \_\_\_\_\_ to \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_
- Alcohol / Drug dated from \_\_\_\_\_ to \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_
- HIV Test Results dated from \_\_\_\_\_ to \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

- Specific Injury/Treatment: \_\_\_\_\_ Department: \_\_\_\_\_ dated from \_\_\_\_\_ to \_\_\_\_\_
- X-Ray:  Images and/or Films  Reports Describe: \_\_\_\_\_
- Laboratory Results dated from \_\_\_\_\_ to \_\_\_\_\_
- Other (specify): \_\_\_\_\_
- Protected Minor Records (Adolescent Confidential). Only applicable for patient requesters 12-17 years old.

Media Preference:  Paper  CD (if available electronically) Delivery Preference:  Mail  Pickup  Fax  Email

**DURATION:** This authorization shall remain in effect for one year from the date of signature unless a different date is specified here \_\_\_\_\_ (date).

**REVOCAATION:** You or your representative can revoke this authorization upon written request. If you revoke, it will not affect information disclosed before the receipt of the written request.

**REDISCLASURE:** Once this health information is disclosed, how the recipient further discloses it may no longer be protected under federal privacy law (HIPAA).

A copy of this authorization is as valid as an original. I have the right to receive a copy of this authorization.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
If not patient, print your name and relationship