Guide to Complete Authorization Form

The purpose of this document is to assist new members with completing the authorization form to support medical records transfer. This document provides a guide to fill out each of the form's sections (A, B, C, D) on page 1 and a completed example for reference on page 2.

Section A: 1) Member Information; 2) Entity member is requesting medical records **FROM**.
Below is an example of all **required** fields. Previous **Kaiser members** may be able to identify the proper office, phone number and email by visiting the following link or calling their doctor: https://healthy.kaiserpermanente.org/southern-california/support/medical-requests#releaseofinformationunitlocations

A

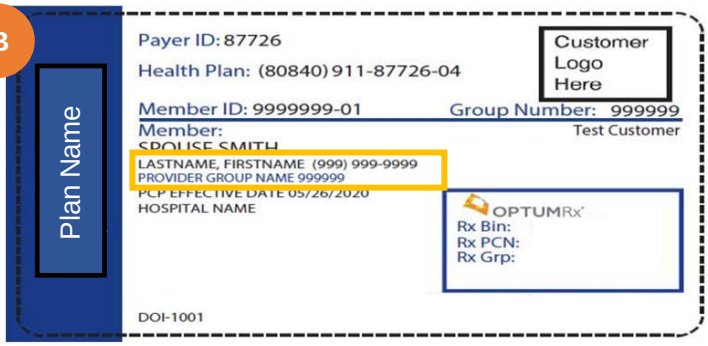
Patient Name: John Doe
MRN: N/A DOB: 05/10/1989
Address: 1234 Spring Street
City: Los Angeles
State: CA Zip: 90001
Phone: (818) 123-4567
Email: John.doe@gmail.com

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION FROM:

Site/Group/Practice/Entity Name: Kaiser – Woodland Hills
Address:
City:
State: Zip:
Phone: ( )
Fax: (818) 719-2670
Email: whroiu@kp.org

Section B: Entity members are requesting the medical records go **TO.**
It is **required** to use an **Insurance Card** to input **provider name, group name and phone number into the Authorization Form**. An example of a card and where to locate this information is below:

B



This authorizes: Kaiser Permanente
clinic(s)/affiliate(s):

to request information as specified below for the following purpose(s):
☑ Continued medical care
☐ Insurance purposes
☐ Other

ENTITY MAY DISCLOSE THIS INFORMATION TO:

Site Name: Edward Castro/OCN – East LA
Address:
City:
State: Zip:
Phone: (323) 226-1100
Fax: ( )
Email: hiscorrespondencedept@optum.com

Section C: Select dates, types, and delivery of medical records.
First, it is **required** to identify what **time period** of records an individual would like to transfer. Second, an individual must note which records should be transferred (Medical Office/Clinical, Hospital, X-Rays) using a checkmark. Third, certain sensitive health information is specifically protected unless an individual authorizes otherwise using a signature – this is **a choice**. Fourth, it is recommended an individual **select electronic** for media type **and email/secure portal/encrypted** for delivery preference.

C

Copies of records or medical record information within the following dates 01/01/2016 to 12/31/2020
☑ Medical office/Clinical records ☑ Hospital records ☐ All records for specified physician or facility/clinic
☐ Records limited to a specific provider _____ or Department: _____
☑ X-ray films ☑ X-ray digital images ☑ Laboratory results ☐ Billing/Claims information
Note: Hospital and medical office records may include disclosure of information related to mental health, alcohol/drug, and HIV references contained within those records as part of this authorization.

The actual treatment records from restricted or sensitive health information are specifically protected, and will not be disclosed unless you sign below.

Mental/behavioral Health records	Signature:
Alcohol/drug dependency treatment records	Signature:
HIV testing results/AIDS treatment	Signature:
Sexually transmitted disease (STD)	Signature:
Genetic testing/test results	Signature:

Media type: ☑ Electronic ☐ Paper Delivery preference: ☑ Email/secure portal/encrypted ☐ US Mail ☐ Pickup

Section D: Sign and date the authorization form.
It is required an individual sign and date the form for submission. If an individual is signing on behalf of someone else, it is required that power of attorney, medical power of attorney, advanced directive or other legal documentation is provided.

D

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

12/31/2020 (Date) John Doe (Signature)

If not the patient, print your name and relationship. Verification of Right to Request, if not patient, e.g. legal documentation, required.

OPTUM®

Example of Completed Authorization Form

EXTERNAL PURPOSES ONLY

A

Patient Name: John Doe
MRN: N/A DOB: 05 / 10 / 1979
Address: 1234 Spring Street
City: Los Angeles State: CA
Zip: 90001 Phone: (818) 123 - 4567
Email: John.doe@gmail.com

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION FROM:

Site/Group/Practice/Entity Name: Kaiser – Woodland Hills
Address:
City:
State: Zip:
Phone: (818) 719-2670 Fax:( )
Email: whroiu@kp.org

Covered Entity will not condition treatment, payment, enrollment or eligibility for benefits on providing, or refusing to provide this authorization.

B

This authorizes clinic(s)/affiliate(s): Kaiser Permanente

to request information as specified below for the following purpose(s):

- [x] Continued medical care
- [ ] Insurance purposes
- [ ] Other

Entity may disclose this information to:

Site Name: Edward Castro/OCN – East LA
Address:
City:
State: Zip:
Phone: (323) 226-1100 Fax:( )
Email: HIScorrespondencedept@optum.com

C

Copies of records or medical record information within the following dates: 01/012010 to 12/31/2020

- [x] Medical office/Clinical records
- [x] Hospital records
- [ ] All records for specified physician or facility/clinic
- [ ] Records limited to a specific provider or Department
- [x] X-ray films
- [x] X-ray digital images
- [x] Laboratory results
- [ ] Billing/Claims information

Note: Hospital and medical office records may include disclosure of information related to mental health, alcohol/drug, and HIV references contained within those records as part of this authorization.

The actual treatment records from restricted or sensitive health information are specifically protected, and will not be disclosed unless you sign below.

Mental/behavioral Health records	Signature: John Doe
Alcohol/drug dependency treatment records	Signature: John Doe
HIV testing results/AIDS treatment	Signature: John Doe
Sexually transmitted disease (STD)	Signature: John Doe
Genetic testing/test results	Signature: John Doe

Media type: [x] Electronic [ ] Paper **Delivery preference:** [x] Email/secure portal/encrypted [ ] US Mail [ ] Pickup

Duration: This authorization shall remain in effect for one year from the date of signature unless a different date is specified here ____/____/____ (date).
Revocation: Patient or Personal Representative can revoke this authorization upon written request. If you revoke, it will not affect information disclosed before the receipt of the written request.
Re-disclosure: Once this health information is disclosed, how the recipient further discloses it may no longer be protected under federal privacy law (HIPAA). California recipients are required to obtain your authorization before disclosing this information.
Fee disclaimer: Federal and state laws permit the entity to charge a reasonable fee for copying/releasing records. State regulated fees for labor and supplies may apply. You should be notified in advance regarding any fees and payment as required.

D

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

12/31/2020	John Doe	
Date	Signature	If not the patient, print your name and relationship. Verification of Right to Request, if not patient, e.g. legal documentation, required.

Office use only: Date received: ____/____/____ Received by (Print name/Initial): ____/____

For questions, please email: HIScorrespondencedept@optum.com
or call: 310-212-0030 and select option #1.