KAISER PERMANENTE®

(*Kaiser Permanente entities are listed on reverse side of this form)

AUTHORIZATION FOR USE OR DISCLOSURE OF PATIENT HEALTH INFORMATION

Note: Fees may apply to certain requests

FILL OUT THIS PORTION ONLY

Patient Name: _____

Medical Record number: _____ Birth Date: _____

Address: _____

City: _____ State: _____

Zip Code: _____ Phone #: ( ) _____

Email: _____

Kaiser Permanente may release this information to: ❑ Check if same as above

Recipient Name: Transamerica or Transamerica's Representatives

Address: _____ City: _____ State: _____ Zip Code: _____

Phone # ( ) _____ Email: _____

This disclosure can be used for the following purpose(s): ❑ Personal Use ❑ Legal ❑ Insurance
❑ Medical Treatment ❑ Medical Condition Verification ❑ Disability ❑ FMLA ❑ Workers' Comp

Check ONLY one of the following three options to identify the health information to be released.

❑ **Option 1:** Form Completion (a substitute form or relevant medical records may be released)

❑ **Option 2:** Last 2 years of Kaiser Permanente Medical Office and Kaiser Foundation Hospital records

❑ **Option 3:** Records as specified. You must complete Step 1 and Step 2 below.

Step 1. Enter date range or date(s) of the records to be released: _____

Step 2. Select types of records to be released:

❑ KP Medical Office ❑ Kaiser Foundation Hospital ❑ Immunization ❑ Lab Results
❑ Diagnostic Images ❑ Copays & Deductibles ❑ Itemized Billing ❑ Pharmacy
❑ Other (provider, department, specialty): _____

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

Check the boxes below if you want this release to include the following information, Otherwise, this information will be excluded.

❑ **Mental Health Treatment Records** ❑ **Addiction Medicine Treatment Records** ❑ **HIV Test Results**

Media Type: ❑ Electronic ❑ Paper **Delivery Preference:** ❑ Electronic ❑ Mail ❑ Pickup

DURATION: Authorization shall remain in effect for one year from the date of signature below. However, in Washington, D.C. permission to release addiction medicine treatment records expires after six (6) months.

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 on the reverse side of this form. 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.

PLEASE PRINT OFF AND HAND SIGN IN BLACK INK

Date _____ Signature _____ If personal representative, print name/relationship _____

NS-9934 (2-16) SPANISH-NS-1614; CHINESE-NS-6274
NCAL: 90258 (REV. 2-16) SPANISH 01782-000; CHINESE 01782-002

ORIGINAL - DISCLOSING PARTY CANARY - PATIENT