KAISER PERMANENTE®

Kaiser Foundation Health Plan, Inc.
Kaiser Foundation Hospitals
The Permanente Medical Group, Inc.

Name: _____

MR#: _____

IMPRINT AREA

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF MEMBER/PATIENT HEALTH INFORMATION

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

I hereby authorize _____
NAME OF DISCLOSING PARTY

_____
ADDRESS

_____
CITY STATE ZIP

to disclose to _____
NAME OF RECIPIENT

_____
ADDRESS

_____
CITY STATE ZIP

records and information pertaining to

_____ _____ _____
NAME OF MEMBER/PATIENT (LIST OTHER NAMES USED) MEDICAL RECORD NUMBER DATE OF BIRTH

_____ _____
ADDRESS TELEPHONE NUMBER

DURATION: This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here _____ (DATE).

REVOCATION: This Authorization is also subject to written revocation by the member/patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this Authorization.

REDISCLOSURE: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

SPECIFY Check the box and initial to specify which type of information is to be disclosed.

RECORDS:

☐ **MEDICAL INFORMATION** _____ (INITIAL)

☐ **PSYCHIATRIC INFORMATION**
_____ (SIGNATURE) _____ (DATE)

☐ **DRUG/ALCOHOL INFORMATION**
_____ (SIGNATURE) _____ (DATE)

☐ **RESULTS OF AN HIV BLOOD TEST**
_____ (SIGNATURE) _____ (DATE)

☐ **OTHER HEALTH INFORMATION** _____ (specify below)

Specify the records to be disclosed: _____

_____

_____

_____

The recipient may use the health information authorized on this form for the following purposes: _____

_____

_____

_____

Date: _____ Signature: _____

If signed by other than member/patient, indicate relationship: _____