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

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

MR#: ______________________

Name: ______________________

IMPRINT AREA

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

If requesting your own records for yourself, specify facilities: ______________________

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.

REDIS-CLOSURE: 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 RECORDS: Check the box, initial and/or sign to specify which type of information is to be disclosed.

- ☐ **MEDICAL INFORMATION** ________ (Initial)
- ☐ **PSYCHIATRIC INFORMATION** Signature ________ Date ________
- ☐ **DRUG/ALCOHOL INFORMATION** Signature ________ Date ________
- ☐ **RESULTS OF AN HIV TEST** Signature ________ Date ________
- ☐ **GENETIC RECORDS** Signature ________ Date ________

Specify the records to be disclosed: ______________________

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

____

A copy of this authorization is as valid as the original.

Member/Patient has a right to a copy of this authorization.

Date Signature If Signed by Other than Member/Patient, Indicate Relationship

90258 (REV. 5-07) HIPAA COMPLIANT
FOR SPANISH USE 01782-", CHINESE 01782-002

DISTRIBUTION: WHITE = CHART - CANARY = MEMBER/PATIENT

FORM NOT TO BE USED FOR RESEARCH