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).

REVOCATION: 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.

REDISCLOSURE: 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

NS-9934 (2-11) HIPAA COMPLIANT SPANISH-NS-1614; CHINESE-NS-6274
90258 (REV. 2-11) SPANISH 01782-000; CHINESE 01782-002

ORIGINAL - DISCLOSING PARTY CANARY - PATIENT