KAISER PERMANENTE®

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: _____
Phone #: ( ) _____
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 disclose information as specified below for the following purpose(s): _____

Kaiser Permanente may disclose this information to:
☐ Check if same as above (disclosure to patient)
Recipient Name: _____
Address: _____
City: _____
State: _____ Zip Code: _____
Phone #: ( ) _____ Fax #: ( ) _____
Email: _____

Copies of records or medical record information within the following dates: _____ **to** _____

☐ Both Hospital and Medical Office Records ☐ Medical Office Records ☐ Hospital Records
☐ Records limited to a specific provider: _____ or department: _____
☐ X-Ray films ☐ X-Ray Digital Images ☐ Laboratory Results

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 mental health, or alcohol/drug departments, or results of HIV antibody tests are specifically protected, and will not be disclosed unless you sign below.

Mental Health department records → Signature: _____
Alcohol / Drug dependency treatment records → Signature: _____
HIV antibody test results → Signature: _____

Media Type: ☐ Electronic ☐ Paper **Delivery Preference:** ☐ Email/Secure Portal ☐ 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: 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). California recipients are required to obtain your authorization before further disclosing this information.

If you are requesting a form to be completed, we may substitute a standardized version of the form that provides the same or similar information requested.

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

SCAL: NS-9934 (6-12) SPANISH-NS-1614; CHINESE-NS-6274
NCAL: 90258 (REV. 6-12) SPANISH 01782-000; CHINESE 01782-002

ORIGINAL - DISCLOSING PARTY CANARY - PATIENT