EXAMPLE

KAISER PERMANENTE®

PATIENT (Member's information)		
NICKNAME / MAIDEN NAME / OTHER		
HEALTH RECORD NO.		
DATE OF BIRTH: (MO/DAY/YR)	PHONE NUMBER ( )	
ADDRESS STREET OR BX NUMBER		
CITY	STATE	ZIP + 4

Authorization for Permanente Advantage to Use/Disclose Protected Health Information

I authorize Permanente Advantage to release the following information for the purpose of: Pre-certification/ Case management / Appeal

Check the ones that apply

Description of information to be used/disclosed (Be as specific as possible):

- ☒ **All records**
- ☒ **X-ray films (describe):**
- ☒ **Other (describe):**

Please send my protected health information to:

(Whom to Disclose Information to)

NAME OF PERSON TO RECEIVE INFORMATION

TITLE (PHYSICIAN, ATTORNEY, ETC.) PHONE NUMBER

STREET ADDRESS

CITY STATE ZIP CODE

If the information to be used/disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be used or disclosed if I **place my initials** in the applicable space next to the type of information:

Intials the ones that apply

_____ Drug/Alcohol diagnosis, treatment or referral information
_____ Mental Health information – including provider notes
_____ HIV/AIDS information
_____ Genetic testing information

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of drug/alcohol diagnosis, treatment or referral information, mental health information and genetic testing information.

You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care service is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.

You may revoke this authorization in writing at any time. For Drug and Alcohol records, you may revoke this authorization orally or in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any use or disclosure already made with your permission cannot be undone. To revoke this authorization, please send a written statement to Permanente Advantage , Release of Information Department at 5855 Copley Drive Suite 250, San Diego, CA. 92111and state that you are revoking this authorization. To revoke this authorization orally, please call Permanente Advantage at 888-529-1553 and state that you are orally revoking this authorization.

I have read this authorization and understand it. Unless revoked, this authorization expires in 24 months or shall remain in effect for a period of time reasonably needed to effect the purpose for which it was given. In Washington, this authorization may be limited by law to 90 days in certain situations.

X Member's Signature
SIGNATURE OF INDIVIDUAL OR PERSONAL REPRESENTATIVE

X Date Signed
DATE

X
DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY

☐ **Identity/Authority verified**

ASSIGNMENT OF BENEFITS: **FOR USE BY INSURANCE CLAIMS DEPARTMENT ONLY**

My signature below authorizes payment by my insurer to the physician/hospital on benefits due to me but not to exceed the balance of my account.

X
SIGNATURE OF INDIVIDUAL OR PERSONAL REPRESENTATIVE

X
DATE

PA0004-1756 03/09

White OPMR - Scan Yellow - Patient

SEE REVERSE SIDE FOR MAILING INSTRUCTIONS

AUTHORIZATION FOR PERMANENTE ADVANTAGE TO RELEASE MEDICAL INFORMATION