Release of Information
11000 E. 45th Avenue, Denver, CO 80239-3004

Phone: 303-404-4700
Fax: 303-404-4750

REQUEST FOR AN ACCOUNTING OF DISCLOSURES

Instructions: Patients must submit a request in writing to obtain a disclosure accounting. This form is also to be used for a parent or guardian requesting disclosure accounting for protected health information of a minor. The first disclosure accounting in a twelve month period is free. Any subsequent disclosure accountings in a twelve month period will be charged at $25 each. Kaiser Permanente is allowed 60 days to respond to this request. (Send form to Release of Information.)

Kaiser ID Number ____________________________________ Today's date: ____ / ____ / ____

Patient's Last Name: __________________________________ First Name: ________________________

Patient's DOB : ____ / ____ / ____ Phone number ______________________________________

Specify time frame from _______________ to ________________

I will pick up, call me when ready at _________________________________

Patient's address if the disclosure accounting is to be mailed:

Street ____

City _______________________________________ State ______________ Zip code_______________

____ _____________________________________
Signature of Patient or Authorized Personal Representative Date

____ _____________________________________
Personal Representative's Name (print) and Relationship Date
(Please attach applicable legal documentation of authority)

Verification of Photo ID ___________________________ Verified By___________________________