COMPLETE ALL AREAS OF THIS FORM AND MAIL TO YOUR PREVIOUS HEALTH CARE PROVIDER

KAISER PERMANENTE®

Kaiser Foundation Health Plan of the Northwest • Kaiser Foundation Hospitals

Authorization to Forward/Disclose Protected Health Information to Kaiser Permanente NW Region

1

PATIENT:		
NICKNAME / MAIDEN NAME / OTHER:		
HEALTH RECORD NUMBER:		
DATE OF BIRTH (MO/DAY/YR):	TELEPHONE NUMBER:	
ADDRESS:	STREET OR BOX NUMBER:	
CITY:	STATE:	ZIP + 4:

2 I hereby authorize: _____

NAME OF SENDING PROVIDER

STREET ADDRESS

CITY STATE ZIP

3 To disclose to **Kaiser Permanente:**

☐ Kaiser Permanente location/address: _____

☐ Kaiser Permanente Radiology Records location/address: _____

4 **The purpose** or need for the exchange and disclosure:

1. Facilitate treatment; 2. Summarize treatment and/or; 3. Facilitate billing/reimbursement from insurance carriers.

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

☐ Records related to (Describe dates, conditions, etc.): _____

☐ All outside Radiology images and associated interpretation reports (Describe dates, conditions, etc.): _____

☐ Other (Describe dates, conditions, etc.): _____

6

Media Type: ☐ Electronic ☐ Paper

Delivery Preference: ☐ Email/Secure Portal ☐ Pickup ☐ Mail

7 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.

INITIALS Mental Health Information

INITIALS Genetic Testing Information

INITIALS HIV/AIDS Information

INITIALS Drug/Alcohol Diagnosis, Treatment, or Referral Information

8

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.

Kaiser Permanente will not condition treatment, payment, enrollment, or eligibility for benefits on providing, or refusing to provide 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. 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 Kaiser Permanente, Release of Information Department at 10220 SE Sunnyside Rd., Clackamas, Oregon 97015 and state that you are revoking this authorization. To revoke this authorization orally, please call Release of Information Department at 503-571-5051 and state that you are orally revoking this authorization.

I have read this authorization and understand it. Unless revoked, this authorization expires in 12 months. In Washington, this authorization shall expire 90 days after the date signed if disclosure is to a financial institution or an employer for purposes other than payment. A copy of this authorization is valid as an original. Member/patient has a right to a copy of this authorization.

– SIGNATURE(S) AND DATE REQUIRED BEFORE PROCESSING –

9 X _____
SIGNATURE OF INDIVIDUAL OR PERSONAL REPRESENTATIVE

10 X _____
DATE

X _____
DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY

– SEE INSTRUCTIONS ON BACK –

Instructions

How to fill out *Authorization to Forward/Disclose Protected Health Information to Kaiser Permanente* form:

1 Member must complete this section. Complete each box as indicated with the following information:
- Patient's name (print clearly)
- Other names the patient has used. If none, leave this box blank
- Health record number
- Date of birth
- Telephone number where you can be reached during the day
- Home street address
- Home city, state, and zip code

2 Write the name of your previous provider or clinic who is releasing your medical information:
- Provider or clinic name
- Street address
- City, state, zip code

3 Check box or write location of where records are to be sent.

4 Circle your purpose or need for the exchange and disclosure of this information.

5 Check the box(es) that apply to your request:
- By checking *Records related to*, please describe dates, conditions.
- By checking *Other*, you will need to describe exactly what you want released. Example: All records regarding my back injury.
- Check *Radiology images* only if you want the actual films to be forwarded.

6 Please indicate media type and delivery preference. If no options are checked, the default will be paper media and UPS delivery.

7 INITIAL for any sensitive information protected by law you want to be released.

8 Please read.

9 Sign the authorization. If you are not the patient, describe your relationship and legal authority to sign. You will be required to provide the legal paperwork.

10 Date the authorization.

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