COMPLETE ALL AREAS OF THIS FORM AND MAIL TO YOUR NON-KP HEALTH CARE PROVIDER

KAISER PERMANENTE®

Kaiser Foundation Health Plan of the Northwest • Kaiser Foundation Hospitals

Consent to Forward/Disclose Protected Health Information to Kaiser Permanente NW Region from an Outside Entity

1

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

2

NAME OF SENDING PROVIDER			
STREET ADDRESS	CITY	STATE	ZIP

3 To disclose to **Kaiser Permanente:**

☐ **Kaiser Permanente Medical Records**
500 NE Multnomah St., Suite 100
Portland, OR 97232
Fax: 1-877-849-4116
Email: NW-Med-Rec@kp.org

☐ **Kaiser Permanente Breast Imaging Records**
3500 North Interstate Ave
Portland, OR 97227
Fax: 503-331-6145
Powershare: Kaiser Permanente Northwest

☐ **Kaiser Permanente Imaging Records (MRI Dept)**
10180 SE Sunnyside Rd
Clackamas, OR 97015
Fax: 1-844-785-2813
Powershare: Kaiser Permanente Northwest

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

☐ Facilitate treatment ☐ Summarize treatment and/or ☐ 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.): _____

You may be required to complete an additional authorization from your Non-KP provider for records covered by 42 CFR Part 2, such as substance abuse disorder treatment.

6 **Delivery method**:

☐ Email/Secure Portal (electronic) ☐ Pickup (paper) ☐ Mail (paper)

7 I understand that federal law does not require written authorization to disclose protected health information when the purpose of the disclosure is treatment, payment, or healthcare operations but does permit a covered entity, like a healthcare provider, to obtain patient consent. I consent to the disclosure of my protected health information as described above.

– SIGNATURE(S) AND DATE REQUIRED BEFORE PROCESSING –

8 X _____
Signature of individual or personal representative

_____
Description of personal representative's authority

9 _____
Date

(see instructions on back)

Instructions

How to fill out *Consent to Forward/Disclose Protected Health Information* to *Kaiser Permanente NW Region*:

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

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

7 Please read.

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

9 Date the consent.

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