Authorization to Disclose Health Plan Information

KAISER PERMANENTE®

1. Individual (Name and information of person whose health information is being disclosed):

Full Name _____ Date of Birth _____ I.D./Subscriber# _____

Address _____ City _____ State _____ Zip _____

Area Code & Telephone Number _____

2. Authorization and Purpose

I request and authorize Kaiser Permanente to discuss, disclose, or make copies of my health information as described in section 3 with the person or organization I designate below. I understand that if the person or organization I authorize to receive and use the information is not a health plan or health care provider, the disclosed information may no longer be protected by federal privacy regulations.

Person/Organization authorized to receive your information _____ Relationship to Individual _____

Address _____ City _____ State _____ Zip _____

Area Code & Telephone Number _____

Purpose of the disclosure i.e., verbal disclosure, copies of information for personal use, for an insurance company, for legal purposes, etc.

3. Specific Description of Information to be Used or Disclosed

I authorize Kaiser Permanente to discuss or disclose to the person or organization named above, all related records in a two year period unless otherwise specified, based on the type(s) of information checked below.

I understand that my health plan records may contain health care information regarding the testing, diagnosis or treatment of sexually transmitted diseases, HIV/AIDS, drug and/or alcohol abuse, and mental health conditions.

Exclude the following information from the records you will discuss or disclose (please check):
☐ Mental health, ☐ Drug and/or alcohol abuse, ☐ Sexually Transmitted Diseases, including HIV/AIDS,
☐ Reproductive Care (minors only)

☐	Health Plan Benefit Information	Includes information contained in your benefit booklet (i.e., copayments, coinsurance eligibility, deductibles, covered services, prescription drug coverage, and other information).
☐	Claim Status and Claim History Information from _____ to _____ m/d/yy m/d/yy	Includes information related to payment of your claims for health care services you received, including pertinent information located on a claim form (i.e., billed amount, your costs, what your health plan paid, general procedure descriptions, payment denial reasons, etc.).
☐	Service Determination Information	Includes any information related to coverage determination information, (i.e., authorization for services and member appeals).
☐	Enrollment and Eligibility Information	Includes information concerning your enrollment eligibility, including application for enrollment, enrollment effective & termination dates, names, addresses, member numbers, and birth dates of subscriber and dependents enrolled in the plan, etc.

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☐	Patient Account Information	Includes premium and billing information related to billing cycles, premium/dues amounts, bank draft changes, dependent changes, etc.
☐	Health care services from provider or supplier	Provider name: _____ (Includes health care information related to services rendered by a specific provider or supplier.)
☐	Other (Please specify)	Other specific information: State specific date, specific time period, event or condition.)

4. **Expiration and Revocation**
This authorization expires _____
(date or event) or when my enrollment in the health plan and/or producer of record assignment is terminated. Otherwise, this authorization will expire in 2 years if expiration date or event is not specified.

Right to Revoke: I understand that I may cancel this authorization at any time by sending written notice to the address listed at the bottom of this form. I understand that revocation of this authorization will not affect any actions already taken by Kaiser Permanente based on this authorization before Kaiser Permanente received my written notice of revocation. I understand I may not be able to revoke this authorization if the purpose of it was to obtain insurance.

5. **Signature** (this document must be signed by the individual, parent of minor child or the individual's authorized representative)

I understand that this authorization is voluntary and that Kaiser Permanente cannot condition my eligibility for benefits, treatment, enrollment or payment of claims on the signing of this authorization. I understand that if I am signing on behalf of a minor child, this authorization will be invalid upon the child reaching age 18, unless there is proof of legal guardianship.

_____ _____
Signature **Date: m/d/yy**

If not the member/enrollee, I am the ☐ Parent ☐ Legal Guardian ☐ Holder of Power of Attorney ☐ Executor or Administrator of Estate

If you are signing as a legal representative or as an agent under a Power of Attorney, Legal Guardian, Executer or Administrator of an Estate, complete the following and attach a copy of the legal documents supporting your authority.

_____ _____
Personal Representative's Name Relationship to Individual

_____
Personal Representative's Address City State Zip

_____
Personal Representative's Area Code & Telephone Number

Before returning, you should keep a copy of this signed authorization for your records.

6. **Mail or fax your completed, signed authorization to the department you are working with:**

Kaiser Foundation Health Plan of Washington
Sales
P.O. Box 35173
Seattle WA 98124-5173
Fax: 206-877-0655

Kaiser Foundation Health Plan of Washington
Member Services
P.O. Box 34590
Seattle, WA 98124-1590
Toll free fax: 1-888-874-1765

If you need assistance completing this form, please contact Kaiser Permanente Member Services at 206-901-4636 or toll free at 1-888-901-4636.