KAISER PERMANENTE®

REQUEST FOR HEALTH INFORMATION

PATIENT INFORMATION

PRINT Patient Name: _____

Birth Date (mm/dd/yyyy): _____

Medical Record Number: _____

Address: _____

City: _____ State: ___ Zip: _____

Phone #: (_____) _____

I REQUEST MY HEALTHCARE PROVIDER:

Provider Name /Organization: _____

Address: _____

Phone: (_____) _____ Fax (_____) _____

TO RELEASE PROTECTED HEALTH INFORMATION TO:

Kaiser Permanente Washington

Clinic/Provider: _____ Phone #: _____ Fax # _____

Address (include mailstop): _____

For the Purpose of: Continued Healthcare Other _____

Protected Health Information may include medical records, emergency and urgent care records, pharmacy records, billing statements, diagnostic imaging reports, transcribed hospital reports, clinician office chart reports, laboratory reports, pathology reports, therapy reports, hospital records (including nursing records and progress notes), and any personal or medical information related to the purpose of this authorization.

I Authorize Release of: All Protected Health Information Specific information _____

Dates of service being requested: **From:** _____ **To** _____

This authorization may include the release of the following sensitive medical information, and I agree to releasing this information: Sexually Transmitted Disease (STDs), AIDS/HIV Diagnoses/Test Reports, Alcohol/Drug Abuse or Treatment, Mental Health, and Minor Reproductive Care

REDISCLOSURE: Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by this rule with the exception of the Alcohol and Drug Abuse records, which are protected by Federal Confidentiality Rules that prohibit the recipient from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2.

I understand that I have the right to withdraw this authorization at any time, except for action already taken, and that such revocation must be in writing to the releasing provider. I understand I do not have to sign this authorization in order to assure treatment or payment.

This authorization expires one year from the date signed OR on the date or event indicated here: _____

SIGNATURE: _____ **DATE:** _____ _____ _____

If personal representative*, print name and relationship: _____

*Documentation may be required to prove authority to sign on behalf of the patient.

Signature of **minor ages 13-17** is required for information related to HIV/AIDS, sexually transmitted diseases, chemical dependency, mental health and reproductive care.

HIM ROI Authorization **Distribution of Original: Eastern Washington to ACN-AC3; Western Washington to RCS**

