KAISER PERMANENTE® **HAWAII REGION**

Patient Request
Release of Protected Health Information
by Clinic/Hospital Staff

MRN:

Name:

DOB:

Original: Revised: 01/07/2020

I request that Kaiser Permanente release the following information on the above-named patient

Information to be disclosed:

☐ Work Slip ☐ Immunization Record ☐ Sports Participation Form

☐ FMLA Form ☐ Other: _____

To:

☐ Self
☐ Other Person or Institution:_____

Method of Delivery:

☐ Pick up

☐ Mail to: _____
Street City State Zip Code

☐ Fax to: (_____) _____

☐ Email to: _____

Risk Acceptance: I understand that transmission of the requested protected health information by fax or unencrypted email may not be secure and accept that risk.

Requested by:

Signature: _____ Date:

Print Name: _____ Relationship to patient:_____

If signed by someone other than the patient or parent of a minor child, please indicate relationship and provide documents to show authority to authorize release of patient's protected health information.

For Kaiser Use Only:

Disclosure of records completed by:

Print Staff Name:_____ Loc/Dept:_____ Date:

Either express scan **OR** interoffice form to Dole Scanning Dept