KAISER PERMANENTE® HAWAII REGION

Patient Request
Release of Records to Patient/Third Party
by KP Release of Information Department

MRN: _____

Patient Name: _____

DOB:

Note: Fees may apply to certain requests

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

☐ Copies of **all** records for services provided for dates to

OR:

Copies of services specified below for dates to (check all that applies)

☐ Clinic Visit/Consultation Notes	☐ Immunization Records	☐ ED Records
☐ Hospital History & Physical	☐ Surgery Reports	☐ Hospital Discharge Summary
☐ Radiology Reports	☐ Laboratory Tests/Results	☐ Cardiac Study/Reports
☐ Radiology Studies (CD & USB only)	☐ MAC/Apple Format Needed	
☐ Digital Photographs (specify):		
☐ Other (describe):		

_____ (initials) I agree to the disclosure of the following information should it be contained in my record: alcohol/drug dependency treatment records.

To: ☐ Self*****

☐ Other Person or Institution: _____

Format: ☐ Email ☐ CD ☐ USB ☐ Paper ☐ Other: _____

Method of Delivery:

☐ Mail to: _____
Street City State Zip Code

☐ *Fax to: _____

☐ *Email to: _____ Please note that email and contents will be sent via secured method unless you indicate otherwise after reading the following statement:

**I understand that there is some level of risk that information sent by fax or unsecured email can be intercepted, forwarded, printed, or read by a third party.* Initial here _____ if you agree to accept the risk of delivery by unsecured means.

Requested by:

Signature: _____ Date: Contact Number: _____

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.

Submit request to Release of Information:

1. Mail: Kaiser Permanente Attn: ROI
   501 Alakawa Street, 2nd Floor
   Honolulu, HI 96817
2. Fax: (866) 609-7402.
3. Email: hi-roi@KP.org