KAISER PERMANENTE®

Kaiser Foundation Health Plan of the Northwest · Kaiser Foundation Hospitals · Kaiser Permanente Health Alternatives

Revocation of Authorization for Disclosure of Member/ Patient Protected Health Information

Release of Information Department
10220 SE Sunnyside Road, Clackamas, OR 97015

PATIENT		
NICKNAME / MAIDEN NAME / OTHER	SOCIAL SECURITY	
HEALTH RECORD NUMBER		
DATE OF BIRTH (MO/DAY/YR)	TELEPHONE NUMBER	
ADDRESS	STREET OR BOX NUMBER	
CITY	STATE	ZIP + 4

This form is to be completed when a member requests to revoke or cancel an existing authorization permitting Kaiser Permanente to release protected Health Information (PHI) to another person or organization. This form is to be completed only by the patient or Personal Representative. This revocation request only applies to the individual(s) or organization(s) listed.

(INITIAL BELOW)

a. _____ I revoke ALL previous authorizations that I have signed.

b. _____ I revoke the authorization I signed on the following date: _____

releasing information to: _____

c. _____ I request the authorization I signed on the following date: _____

releasing information to: _____ be modified to

revoke authorization to release the following specific protected health information

(list information that you DO NOT want released): _____

_____

I understand that my written revocation will be effective upon receipt, but will not be effective to the extent that the requester or others have acted in reliance upon the authorization that I provided prior to this revocation.

I understand that revocation will not apply to information that has already been released nor will it apply to my insurance company when the law provides the insurer with the right to contest a claim under my policy or the policy itself.

Not withstanding this revocation, Kaiser Permanente shall continue to disclose PHI to third parties as required by law, which may include a disclosure(s) to the individual(s) or entity named in this revocation.

_____ _____

Signature of Patient/Authorized Individual Date

_____

Patient/Authorized Individual's Address

_____

Patient/Authorized Individual's Telephone Number

Submit to Release of Information Department at Kaiser Permanente Regional Process Center