KAISER PERMANENTE®

(*Kaiser Permanente regions are listed on reverse side of this form)

AUTHORIZATION FOR USE OR DISCLOSURE OF PATIENT HEALTH INFORMATION

Note: Fees may apply to certain requests

See reverse side for instructions to fill out this form.
Failure to follow instructions may result in processing delay.

1. PATIENT INFORMATION

PRINT Patient Name: _____
Birth Date (mm/dd/yyyy): _____
Medical Record Number: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone #: (_____) _____
Email: _____

2. KAISER PERMANENTE MAY RELEASE THIS INFORMATION TO: ❑ **Check if the same as 1 above**

Organization or person: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: (_____) _____ Fax (_____) _____
Email: _____

DELIVERY METHOD FOR RECORDS: ❑ Secure Email ❑ Fax ❑ Paper/Mail (may take longer to process)

3. PURPOSE OF RELEASE: ❑ Doctor ❑ Legal ❑ Insurance ❑ Medical Leave ❑ Personal / Other

4. INFORMATION FROM _____/_____/_____ TO _____/_____/_____ TO BE RELEASED:

❑ Medical records ❑ Billing records
❑ Immunizations ❑ Radiology reports: _____
❑ Pharmacy records ❑ Radiology images (on CD): _____
❑ Other: (provider, department, specialty): _____

5. PATIENT AUTHORIZATION: I understand that:

- ✓ Information released may include information regarding the testing, diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, chemical dependency or mental health and for patients ages 13-17, information regarding reproductive care. I give my specific authorization for this information to be released.
- ✓ Generally, Kaiser Foundation Health Plan of Washington and any other entity covered by the Health Insurance Portability and Accountability Act of 1996, may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. If this authorization is for purposes of determining enrollment, eligibility, underwriting or risk rating prior to enrollment, not signing or revoking this authorization may impact enrollment or benefit determinations by Kaiser Foundation Health Plan of Washington.
- ✓ I may revoke this authorization in writing. If I revoke my authorization, it will not affect any actions already taken based upon this authorization.
- ✓ Once disclosed, health care information may be subject to redisclosure by the recipient and may no longer be protected under health information privacy laws.

6. SIGNATURE: _____ **DATE:** _____/_____/_____

If personal representative*, print name and relationship: _____

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

7. MINOR SIGNATURE: _____ **DATE:** _____/_____/_____

Signature of **minor ages 13-17** is required for certain information, see number 7 on instruction page)

8. This authorization expires 90 days from the date signed OR on the date or event indicated here:

_____

Business Office/Clinic Staff: Has this request been processed?

WWA YES, already processed: send to Scanning at RCS	**EWA YES, already processed: send to Scanning at ACN-AC3**
WWA NO, needs processing: fax to ROI at 206-630-6849	**EWA NO, needs processing: fax to ROI at 509-232-3127**

Please visit kp.org for contact information for the following Kaiser Permanente regions:

- California
- Colorado
- Georgia
- Hawaii
- Mid-Atlantic States (Maryland, Virginia & Washington DC)
- Northwest (Oregon, Longview & Vancouver, Washington)
- Washington

INSTRUCTIONS:

1. **PATIENT INFORMATION:** Print name of patient, birth date, medical record number (if known), address, phone number and email.
2. **RECIPIENT INFORMATION:** Print name, address, phone number, fax number and email address.
   Delivery method: Electronic delivery is recommended. Please PRINT the email address clearly.
3. **PURPOSE:** Check the box that applies to the reason the records are being requested.
4. **INFORMATION TO BE RELEASED:**
   - Medical records – a maximum of 10 years of records
   - Billing records – premium payments not included
   - Radiology images – please specify images and/or dates needed
5. Read the **PATIENT AUTHORIZATION section.**
6. **SIGNATURE:** Sign and date. Personal representative should print name and indicate relationship to the patient. Documentation may be required to prove authority to sign on behalf of the patient.
7. **MINOR SIGNATURE:** Minor patients ages 13 to 17 must authorize the release of information related to HIV/AIDS, sexually transmitted diseases, chemical dependency, mental health and reproductive care.
8. **EXPIRATION:** If no date or event is given, authorization will expire 90 days from date signed.

To submit your request, please fax your completed form to the appropriate locations listed below. Fax submission is preferred; you may also send by mail or email. Please visit our website **www.kp.org/wa** for additional copies of this form or for more information.

Western Washington
Kaiser Foundation Health Plan of Washington
Release of Information
MAILSTOP: RCG-D1N-02
PO Box 9812
Renton, WA 98057-9054

Phone: 206-630-6848 or toll-free 1-866-656-4184
Hours: 8 a.m. to 5 p.m.
Email: KPWA-ROI@kp.org
Fax: 206-630-6849

Eastern Washington
Kaiser Foundation Health Plan of Washington
Health Information Management
MAILSTOP: ACN-AC3
PO Box 204
Spokane, WA 99210-9809

Phone: 509-241-7824
Hours: 8 a.m. to 5 p.m.
Email: KPWA-ROI@kp.org
Fax: 509-232-3127

To request Radiology Images <u>ONLY</u> (x-rays, MRI's, CT's, mammograms etc.), please send requests to:
Kaiser Foundation Health Plan of Washington
Central Imaging Center
201 16th Ave E
Seattle, WA 98112

Phone: 206-326-3715
Fax: 206-326-2007

Kaiser Permanente Nondiscrimination Notice and Language Access Services

KAISER PERMANENTE®

KAISER PERMANENTE NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc. ("Kaiser Permanente") comply with applicable federal civil rights laws and does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender identity, or any other basis protected by applicable federal, state, or local law. We also:

Provide free aids and services to people with disabilities to help ensure effective communication, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, and accessible electronic formats)
- Assistive devices (magnifiers, Pocket Talkers, and other aids)

Provide free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact Kaiser Permanente.

If you believe that Kaiser Permanente has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, you can file a grievance. Please call us if you need help submitting a grievance. The Civil Rights Coordinator will be notified of all grievances related to discrimination.

Kaiser Permanente
Phone: 206-630-4636
Toll-free: 1-888-901-4636
TTY Washington Relay Service: 1-800-833-6388 or 711
TTY Idaho Relay Service: 1-800-377-3529 or 711
Electronically: kp.org/wa/feedback

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F
HHH Building
Washington, DC 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

For Medicare Advantage Plans Only: Kaiser Permanente is an HMO plan with a Medicare contract. Enrollment in Kaiser Permanente depends on contract renewal.

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LANGUAGE ACCESS SERVICES

English: ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-888-901-4636 (TTY: 1-800-833-6388 or 711).

Español (Spanish): ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

中文 **(Chinese)**：注意：如果您使用繁體中文，您可 以免費獲得語言援助服務。請致電 1-888-901-4636 (TTY: 1-800-833-6388 / 711)。

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

한국어(Korean): 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-901-4636 (TTY: 1-800-833-6388 / 711) 번으로 전화해 주십시오.

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-901-4636 (телетайп: 1-800-833-6388 / 711).

Filipino (Tagalog): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

Українська (Ukrainian): УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-888-901-4636 (телетайп: 1-800-833-6388 / 711).

ភាសាខ្មែរ **(Khmer)**៖ របយ័ត៖ បើសិនអកនិយែខរ, សេជំនួយែផក យេមិនគិតល គឺចនសំប់បំរេអក។ ចូរទូ រស័ព

1-888-901-4636 (TTY: 1-800-833-6388 / 711)។

日本語 (Japanese): 注意事項：日本語を話される場 合、無料の言語支援をご利用いただけます。 1-888-901-4636 (TTY: 1-800-833-6388 / 711) まで、 お電話にてご連絡ください。

አማርኛ (Amharic) ፥ ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-888-901-4636 (መስማት ለተሳናቸው: 1-800-833-6388 / 711).

Oromiffa (Oromo): XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

ਪੰਜਾਬੀ **(Punjabi)** ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-888-901-4636 (TTY: 1-800-833-6388 / 711) 'ਤੇ ਕਾਲ ਕਰੋ।

العربية (Arabic): لديكم حق الحصول على مساعدة ومعلومات في ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان .اتصل برقم 1-888-901-4636 رقم هاتف الصم والبكم: (1-800-833-6388 / 711) .

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

ພາສາລາວ (Lao): ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາລາວ, ການບໍ ລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມ ໃຫ້ທ່ານ. ໂທຣ 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

Srpsko-hrvatski (Serbo-Croatian): OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-901-4636 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-800-833-6388 / 711).

Français (French): ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-901-4636 (ATS: 1-800-833-6388 / 711).

Română (Romanian): ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

Adamawa (Fulfulde): MAANDO: To a waawi Adamawa, e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

فارسی (Farsi): توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد .با 1-888-901-4636 (TTY: 1-800-833-6388 / 711) تماس بگیرید.