Authorization to Use and Disclose Protected Health Information to Kaiser Foundation Health Plan of Georgia, Inc.

FORM INSTRUCTIONS

The purpose of this form is to obtain your consent in the release of your medical records and medical history from your prior physician to your current Kaiser Permanente physician. By allowing for the transfer of your medical records, you will assist your Kaiser Permanente physician in providing for continuity of care.

1. “I hereby authorize”
   Provide your prior physician, medical office or hospital (if applicable) contact information within this section.

2. “To disclose to”
   If you have already selected or been assigned a Primary Care Physician with Kaiser Permanente, please indicate that individual’s name on the first line of this section.

3. “Distribution Note”
   Kaiser Permanente is able to accept your records in the form of CD, flash drive, fax, or paper.

4. “Records and information pertaining to”
   This section should be completed with your personal information or that of your child’s information (if under age 18). All adult dependents must complete their own individual form. Please check the box, next to “I am requesting” for the type of records being requested.

5. “Specify Records to be Released”
   If you have had a physical exam within the last year, please request those records along with any associated lab work. If you have not received a physical exam within the last year, check the second box and request your General Medical Information from the past year. For all other health record needs, check the appropriate box that matches your request.

6. “Duration” - No action required.

7. “Recipient Use”
   If not already filled in, please select “Continuity of Care” as “Recipient Use”.

Sign, date, and indicate who is requesting the release of medical information.

Fax, mail, or hand-deliver this form to the party from which you are requesting your records. The party is allowed 30 days to submit your requested records to Kaiser Permanente in any of the four forms listed in the “Distribution Note” section.

***Please be aware that you may incur charges for your records request. These charges are determined by the party from which you are requesting records and are not covered by Kaiser Permanente.***
AUTHORIZATION TO USE AND DISCLOSE
PROTECTED HEALTH INFORMATION TO
Kaiser Foundation Health Plan of Georgia, Inc.

I hereby authorize:                                        To disclose to:

Provider or Clinic                                        Kaiser Permanente – Medical Records Administration Dept.
Street Address                                            4000 Dekalb Technology Parkway, Bldg 200 Suite 200
City          State       Zip                               Atlanta, GA   30340

Records and information pertaining to:                   Phone: (770) 220-3870  Fax: (877) 856-6891

Name of Member/Patient (List other names used)            Distribution Note:
Medical Record Number                                    Kaiser Permanente physicians are able to accept medical
Date of Birth (MM/DD/YYYY)                                records in electronic or paper formats. Please feel free to
Medical Record Number                                    provide records on CD, Flash Drive, Fax, or Paper.
Daytime Phone Number

I am requesting:                                          Distribution Note:
My own records                                          Kaiser Permanente physicians are able to accept medical
My child’s records (under 18 years old)                   records in electronic or paper formats. Please feel free to
Records for a child / adult for whom I am a personal representative (copy of signed supporting legal document provide records on CD, Flash Drive, Fax, or Paper.
showing your status as a personal representative with access to member’s/patient’s records must accompany request)

Specify Records to be Released:

Last Physical Exam with Lab/Test Results (date) __________
General Medical Information (from _____ to _____)
Radiology Images (exams/dates) ____________________________
Laboratory Results (dates) _____________________________
Behavioral Health Dept / Psychiatric Treatment Records± (from _____ to _____)
Chemical Dependency Recovery Prog. Dept /Alcohol/Drug Treatment Program Records (from _____ to _____)
HIV Test Results / Treatment Records (from _____ to _____)
Other Records (specify): _________________________________

Duration: This authorization will remain in effect for one year from date of your signature unless you specify a
different period here: __________________________ (Must be for a period of less than one year.)

Revocation: This authorization is subject to written revocation by the member/patient at any time. The written
revocation will be effective upon receipt by the Provider/Clinic listed above (with a copy sent to Kaiser
Permanente’s HIMS Department), except to the extent that the disclosing party or others have acted in reliance on
this authorization. Written revocation should be mailed/faxed to the addresses listed at the top of this authorization.

Redisclosure: I understand that information disclosed pursuant to this authorization may be subject to
redisclosure and no longer be protected by the HIPAA privacy rules.

Conditions: Kaiser Permanente may not condition treatment, payment, enrollment or eligibility for benefits on
whether you sign this authorization.

Recipient Use: Please select the purpose(s) of the requested use or disclosure of the health information:
Continuity of Care    Insurance (select one or both)

A copy of this authorization is valid as an original. Member/patient has a right to a copy of this authorization.

Date    Signature of Patient or Personal Representative     Indicate Relationship (if Signed by Other than Patient)