

Authorization for Release of Protected Health Information

Note: Fees may apply to certain requests

Patient Name: _____

MR#: _____ BD: _____

SSN (last 4 digits only): _____

*I hereby authorize: Kaiser Permanente Other Facility/Provider: _____

*To disclose the following information on the above named individual:

- Both Hospital and Clinic Records Clinic Records Hospital Records
 Records of Specific Provider: _____ or Dept. _____
 X-Ray Films/Images X-Ray Report/Results Lab Results Immunizations
 Other (please specify: _____)

*Release to: Kaiser Permanente Attention: _____
(KP Provider or Clinic Department)

Patient Physician, Other Person or Institution: _____

Address: _____

City: _____ State: _____ Zip Code: _____

*For the purpose of:

- At the Request of the Individual Legal Purposes Insurance School
 Continuing Care/Treatment Other: _____

Record format:

Unless otherwise indicated, medical records will be sent by electronic media.

- Paper CD Flash Drive Email address: _____

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

***DURATION:** Unless a different date is specified here _____ (date) this authorization shall remain in effect for one year from date of signature.

REVOCAION: I can revoke this authorization by submitting a letter to Health Information Management at 501 Alakawa Street 2nd floor, Honolulu, HI 96817. A revocation will not affect information disclosed prior to receipt of the revocation.

REDISCLOSURE: Information released under this authorization may be re-released by the recipient and no longer protected under federal privacy rules.

I understand that Kaiser Permanente may not condition my treatment, payment, enrollment or eligibility for benefits on providing or refusing to provide this authorization, except for (i) research related treatment, (ii) health care provided solely for disclosure to a third party, or (iii) health plan initial enrollment/eligibility determinations, risk rating or underwriting.

I understand I have a right to receive a copy of this authorization.

*Date: _____ *Signature: _____ *Print Name: _____

If signed by someone other than the patient or parent of a minor child, please indicate relationship. Submit documents to show authority to request information on the patient.

*Relationship to Patient: _____ Phone Number: (_____) _____

*Items that MUST be completed for authorization to be valid