



Kaiser Foundation Health Plan, Inc.
Kaiser Foundation Hospitals
The Permanente Medical Group, Inc.

MR #: _____

Name: _____

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF MEMBER/PATIENT HEALTH INFORMATION

IMPRINT AREA

I understand that Kaiser Permanente will not condition treatment, payment, enrollment, or eligibility for benefits on my providing or refusing to provide this authorization.

I hereby authorize:

To disclose to:

Name of Disclosing Party

Name of Recipient

Address

Address

City State ZIP

City State ZIP

If requesting your own records for yourself, specify facilities: _____

Records and information pertaining to:

Name of Member/Patient (List Other Names Used)

Medical Record Number

Date of Birth

Address

Telephone Number

DURATION: This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here _____ (Date).

REVOCATION: This authorization is also subject to written revocation by the member/patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization.

REDIS- I understand that the recipient may not lawfully further use or disclose the health
CLOSURE: information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

SPECIFY Check the box, initial and/or sign to specify which type of information is to be disclosed.

RECORDS: ☐ **MEDICAL INFORMATION**

(Initial)

☐ **PSYCHIATRIC INFORMATION**

Signature Date

☐ **DRUG/ALCOHOL INFORMATION**

Signature Date

☐ **RESULTS OF AN HIV TEST**

Signature Date

☐ **GENETIC RECORDS**

Signature Date

Specify the records to be disclosed: _____

The recipient may use the health information authorized on this form for the following purposes: _____

A copy of this authorization is as valid as the original.

Member/Patient has a right to a copy of this authorization.

Date Signature If Signed by Other than Member/Patient, Indicate Relationship