



Kaiser Foundation Hospitals  
Permanente Medical Groups

### AUTHORIZATION FOR USE OR DISCLOSURE OF PATIENT HEALTH INFORMATION

Note: Fees may apply to certain requests

Patient Name: \_\_\_\_\_  
 Kaiser # \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_  
 State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Phone #: ( ) \_\_\_\_\_  
 Email: \_\_\_\_\_

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

This authorizes the following Kaiser Permanente Medical Center(s): \_\_\_\_\_

to disclose information as specified below for the following purpose(s): \_\_\_\_\_

Kaiser Permanente may disclose this information to:

Check if same as above (disclosure to patient)

Recipient Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_  
 State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Phone #: ( ) \_\_\_\_\_ Fax #: ( ) \_\_\_\_\_  
 Email: \_\_\_\_\_

Copies of records or medical record information within the following dates: \_\_\_\_\_ to \_\_\_\_\_

- Both Hospital and Medical Office Records
- Medical Office Records
- Hospital Records
- Records limited to a specific provider: \_\_\_\_\_ or department: \_\_\_\_\_
- X-Ray films
- X-Ray Digital Images
- Laboratory Results

**NOTE: Hospital and Medical Office records may include disclosure of information related to mental health, alcohol/drug, and HIV references contained within those records as part of this authorization.**

**The actual treatment records from mental health, or alcohol/drug departments, or results of HIV antibody tests are specifically protected, and will not be disclosed unless you sign below.**

Mental Health department records → Signature: \_\_\_\_\_  
 Alcohol / Drug dependency treatment records → Signature: \_\_\_\_\_  
 HIV antibody test results → Signature: \_\_\_\_\_

Media Type:  Electronic  Paper      Delivery Preference:  Email/Secure Portal  Mail  Pickup

**DURATION:** This authorization shall remain in effect for one year from the date of signature unless a different date is specified here \_\_\_\_\_ (date).

**REVOCAION:** You or your representative can revoke this authorization upon written request. If you revoke, it will not affect information disclosed before the receipt of the written request.

**REDISCLASURE:** Once this health information is disclosed, how the recipient further discloses it may no longer be protected under federal privacy law (HIPAA). California recipients are required to obtain your authorization before further disclosing this information.

If you are requesting a form to be completed, we may substitute a standardized version of the form that provides the same or similar information requested.

A copy of this authorization is as valid as an original. I have the right to receive a copy of this authorization.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
If not patient, print your name and relationship