



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

Name: _____

MR#: _____

**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

NAME OF DISCLOSING PARTY _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

to disclose to

NAME OF RECIPIENT _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

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 _____.

REVOCACTION: 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.

REDISCLASURE: I understand that the recipient may not lawfully further use or disclose the health 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 and initial 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 BLOOD TEST** _____ SIGNATURE _____ DATE _____
 - OTHER HEALTH INFORMATION** _____ (specify below)

Specify the records to be disclosed: _____

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

Date: _____ Signature: _____

If signed by other than member/patient, indicate relationship: _____