



Kaiser Foundation Health Plan of the Northwest • Kaiser Foundation Hospitals
Kaiser Permanente Health Alternatives

Authorization for Kaiser Permanente to Use/Disclose Protected Health Information

PATIENT		
NICKNAME / MAIDEN NAME / OTHER		SOCIAL SECURITY
HEALTH RECORD NO.		
DATE OF BIRTH: (MO/DAY/YR)		PHONE NUMBER ()
ADDRESS		STREET OR BX NUMBER
CITY	STATE	ZIP + 4

I authorize Kaiser Permanente to release the following information for the purpose of: _____

Description of information to be used/disclosed (Be as specific as possible):

- All records related to (describe): _____
- X-ray films (describe): _____
- Other (describe): _____

Please send my protected health information to:

NAME OF PERSON TO RECEIVE INFORMATION _____

TITLE (PHYSICIAN, ATTORNEY, ETC.) _____ PHONE NUMBER _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

If returning this Authorization to Kaiser Permanente, send to:

Medical Reports
10220 SE Sunnyside Rd
Clackamas, Oregon 97015

If the information to be used/disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be used or disclosed if I **place my initials** in the applicable space next to the type of information:

- _____ Drug/Alcohol diagnosis, treatment or referral information
- _____ Mental Health information
- _____ HIV/AIDS information
- _____ Genetic testing information

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of drug/alcohol diagnosis, treatment or referral information, mental health information and genetic testing information.

You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care service is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any use or disclosure already made with your permission cannot be undone. To revoke this authorization, please send a written statement to Kaiser Permanente, Medical Reports Department at 10220 SE Sunnyside Rd., Clackamas, Oregon 97015 and state that you are revoking this authorization.

I have read this authorization and I understand it. Unless revoked, this authorization expires within 12 months in Oregon and 90 days in Washington.

X _____
SIGNATURE OF INDIVIDUAL OR PERSONAL REPRESENTATIVE

X _____
DATE

X _____
DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY

Identity/Authority verified

ASSIGNMENT OF BENEFITS: FOR USE BY INSURANCE CLAIMS DEPARTMENT ONLY

My signature below authorizes payment by my insurer to the physician/hospital on benefits due to me but not to exceed the balance of my account.

X _____
SIGNATURE OF INDIVIDUAL OR PERSONAL REPRESENTATIVE

X _____
DATE

AUTHORIZATION FOR KAISER PERMANENTE TO RELEASE MEDICAL INFORMATION