KAISER PERMANENTE®

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
2101 E. Jefferson Street Rockville, MD 20849-6611

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

1. I AUTHORIZE:

_____
Name of sending person/organization

_____
Street Address

_____
City State Zip Code

_____
Telephone Number

2. RELEASE TO: Fax ☐ Mail ☐ Pickup ☐

_____
Name of receiving person/organization

_____
Street Address

_____
City State Zip Code

_____
Telephone Number

3. INFORMATION TO BE RELEASED: (Check all that apply)

☐ Attached Form ☐ Immunization Record only ☐ Copy of medical record for last two years (includes immunizations)
☐ Other: _____

4. SPECIAL AUTHORIZATION: (Check all that apply and sign below)

By signing below, you are authorizing Kaiser Permanente to release information regarding:
☐ alcohol, ☐ drugs, ☐ mental health, ☐ sexually transmitted diseases, ☐ HIV, ☐ AIDS, or ☐ AIDS Related Complex (ARC).
The information released may include: treatment summaries, progress notes, test results, verbal exchange between treating persons or facilities.
Other: _____
I understand that this authorization will automatically expire twelve months from the date signed.
Signature: _____

5. RELEASE RECORDS DATING FROM: _____ /_____ /_____ **TO** _____ /_____ /_____

6. PURPOSE OR NEED FOR DISCLOSURE: (Check applicable purpose)

☐ Continued Medical Care ☐ Payment of Insurance Claim ☐ Legal
☐ Personal ☐ Worker's Compensation Claim ☐ Other: _____

7. FOR CONTRACTS ISSUED IN THE STATE OF MARYLAND: I understand that this authorization shall be valid for a period not to exceed one (1) year. **FOR INSURANCE CONTRACTS ISSUED IN THE COMMONWEALTH OF VIRGINIA OR DISTRICT OF COLUMBIA:** I understand that this authorization shall be valid: (a) in the case of authorizations signed for the purpose of collecting information in connection with an application for an insurance policy, a policy reinstatement, or a request for change in policy benefits: (1) Thirty months from the date the authorization is signed if the application or request involves life, accident and sickness, or disability insurance; (b) in the case of authorizations signed for the purpose of collecting information in connection with a claim for benefits under an insurance policy: (1) the term of coverage of the policy if the claim is for an accident and sickness insurance benefit; (2) the duration of the claim if the claim is not for an accident and sickness insurance benefit.

8. I UNDERSTAND that I (or the person authorized to act on my behalf) am entitled to receive a copy of this authorization form and that the Requester may be provided a copy of this authorization. I also understand that I am entitled to inspect my records and that a reasonable fee may be charged for duplication of records. An estimate of charges will be provided upon request prior to duplication.

9. I UNDERSTAND that I may revoke this authorization at any time (in writing) except to the extent that action has been taken in reliance on it. To revoke this authorization, please provide a written statement to Kaiser Permanente Health Information Management Services.

10. TO THE PERSON(S) RECEIVING RECORDS: I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected by 45 CFR Subtitle A, Subchapter C, Section 164.508. If this authorization pertains to alcohol or drug information, please note that this information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for release of medical or other information is not sufficient for this purpose. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

11. I AM AUTHORIZING and directing any physician, nurse, hospital or other provider having treated or attended me or any of my family members listed on this form, and having possession of any records or information with respect thereto, to provide such information or records to Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. upon request.

_____ _____ _____/_____/_____
Patient Name (Printed) Medical Record Number Patient's Date of Birth

_____ (_____) _____
Present Mailing Address Daytime Telephone Number

_____ _____ _____/_____/_____
City State Zip Code Patient/Legal Representative Signature Date