KAISER PERMANENTE®

Kaiser Foundation Hospitals
The Permanente Medical Group, Inc.

MR #: _____

Name: _____

IMPRINT AREA

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION TO KAISER PERMANENTE

I hereby authorize:

Provider or Clinic

Street Address

City State ZIP

to disclose to:

Kaiser Permanente at Location

Name of Provider Street Address

City State ZIP

Records and information pertaining to:

Patient Name | Date of Birth | Daytime Phone | Medical Record Number

Street Address | City | State | ZIP

The type and amount of information to be disclosed is as follows *(specify dates where appropriate)*:

- ☐ Most recent 2 years of record for adult patients
- ☐ Pediatric Record for minor patients
- ☐ Immunization Record
- ☐ Radiology Reports, from date _____ to _____
- ☐ Radiology Images (exam/date): _____
- ☐ All Breast Images and Breast Imaging Reports
- ☐ Laboratory Results, from date _____ to _____
- ☐ Other records not listed (specify): _____

1. I understand that the medical information released may include any and all information concerning treatment of medical history, mental illness, alcohol/drug abuse, and HIV/AIDS information.
2. I understand that although disclosure of health information for treatment purposes from provider to provider is generally considered a professional courtesy, a health care provider may charge me a fee for disclosure of this health information.
3. I understand that a Kaiser Permanente provider may review the records to determine what content ultimately becomes part of the patient's Kaiser Permanente medical record.

PURPOSE: The health information disclosed will be used for continuing care/treatment purposes.

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

REVOCATION: 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.

REDISCLOSURE: 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.

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

Signature of Patient or Personal Representative | Date | Personal Representative's Name Print) and Relationship