1 MEMBER MUST COMPLETE THIS SECTION

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

KAISER PERMANENTE

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

Authorization for Kaiser Permanente to Use/Disclose Protected Health Information

2 I authorize Kaiser Permanente to release the following information for: insurance application

3
PDC Retrievals
PO BOX 150356
KEW GARDENS, NY 11415
FAX 877-516-1476

PHONE NUMBER

CITY STATE ZIP CODE

4 **The purpose or need for the exchange and disclosure of this information is to:**

- ☐ Facilitate treatment;
- ☐ Summarize treatment and/or;
- ☐ Facilitate billing/reimbursement from insurance carriers.
- ☑ _____

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

5
- ☐ All records
- ☐ X-ray films (describe): _____
- ☐ Other (describe): _____

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:

6
- _____ Drug/Alcohol diagnosis, treatment or referral information
- _____ Mental Health information – including provider notes
- _____ 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, Release of Information Department at 10220 SE Sunnyside Rd., Clackamas, Oregon 97015 and state that you are revoking this authorization. To revoke this authorization orally, please call Release of Information Department at 503-571-5051 and state that you are orally revoking this authorization.

I have read this authorization and understand it. Unless revoked, this authorization expires in 12 months. In Washington, this authorization shall expire 90 days after the date signed if disclosure is to a financial institution or an employer for purposes other than payment.

7 X _____
SIGNATURE OF INDIVIDUAL OR PERSONAL REPRESENTATIVE

8 X _____
DATE

X _____
DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY

SEE REVERSE SIDE FOR MAILING INSTRUCTIONS

AUTHORIZATION FOR KAISER PERMANENTE TO RELEASE MEDICAL INFORMATION