KAISER PERMANENTE®

Stapleton Support Services
11000 E. 45th Avenue, Denver, CO 80239-3004
TTY: 1-800-659-2656

Authorization to Use and/or Disclose Protected Health Information

Release of Information • Phone: 303-404-4700 • Fax: 303-404-4750

☐ **I authorize Kaiser Foundation Health Plan of Colorado (KFHP) and/or the Colorado Permanente Medical Group (CPMG) to release the health information of the individual named below.**

☐ **I authorize my previous Health Care Provider to release the health information of the individual named below, to the Kaiser Foundation Health Plan of Colorado (KFHP) and/or the Colorado Permanente Medical Group (CPMG). Please fax to Data Integrity Department, at 303-404-4850, or mail to the address listed above.**

_____ _____
Patient Name Medical Record Number

_____
Street Address City State ZIP

_____ _____
Phone number Date of birth

I hereby authorize: _____ (Name of sending person/organization)

_____
Street address City State ZIP

_____ Method: ☐ Pick up in person ☐ Mail ☐ Fax
Phone Number

To disclose to the following individual or organization: _____

_____
Street address City State ZIP

_____
Phone number

****Kaiser Permanente will bill the receiving party or organization for charges related to the copies of the records. Patients will <u>not</u> be billed for these charges.**

Purpose of Use or Disclosure

☐ FMLA/LOA ☐ Narrative ☐ Employer Request ☐ Personal Use ☐ Continuity of Care
☐ Return to Work ☐ Insurance ☐ Social Security ☐ Attorney ☐ Workers Compensation
☐ Other (Specify): _____

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

☐ Immunizations
☐ Most recent _____ (years) of record
☐ Entire medical record
☐ Other (Specify): _____
☐ Laboratory Results: ___/___/___ to ___/___/_____
☐ X-Ray Reports: ___/___/___ to ___/___/_____
☐ FMLA/Return to work paperwork

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NOTE: I understand that the medical information released by this authorization may include information concerning treatment of physical or mental illness, past medical history, alcohol/drug abuse, HIV/AIDS, or other sensitive information.

I am requesting that Kaiser Permanente release these records in the following format:

☐ Paper format ***or*** ☐ Electronic copies on CD (<u>only</u> applies to records maintained by Kaiser Permanente in electronic medical record)

_____ _____

Patient Name (please print) Medical Record Number

- I understand this authorization will expire, without my expressed revocation, either one year from the date of signing, or the date the minor child becomes an adult according to state law, whichever occurs first. I understand that I may revoke this authorization by sending a request in writing to the address at the top of this form, except to the extent that action has been taken based on it. I understand that revocation will not apply to information that has already been released as specific by this authorization or to my insurance company when the law provides my insurer with the right to contest a claim under my policy or the policy itself.
- I understand that Kaiser Permanente will only release requested records up to the date of my signature, and does not include future records. If I request to have records disclosed in the future, I will be required to complete a new authorization.
- I understand that authorization for the disclosure of this health information is voluntary and I can refuse to sign this authorization. KFHP/CPMG cannot condition treatment, payment, or enrollment in the health plan or eligibility for benefits on the signing of an authorization, except as otherwise permitted by law. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure by the receiving party, which may not be protected by federal confidentiality rules.

➡ _____ _____

Signature of Patient or Authorized Personal Representative Date

_____

Personal Representative's Name and Relationship *(please attach applicable legal documentation of authority)*

For Kaiser Permanente Office Use Only: Verification of Photo Identification

ID# and State _____ Verified by:_____