KAISER PERMANENTE®

AUTHORIZATION TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION

1. I authorize Kaiser Foundation Health Plan of Ohio and/or The Ohio Permanente Medical Group, Inc. to disclose and or receive for use the following information for the individual named below:

Patient Name: _____ Kaiser Medical Record #: _____

Address: _____

City/State/Zip: _____

Phone #: ( ) _____ Date of Birth _____

2a. **I AUTHORIZE:**

_____
Name of sending person/organization

_____
Street Address

_____
City State Zip Code

2b. **TO RELEASE TO:**

_____
Name of receiving person/organization

_____
Street Address

_____
City State Zip Code

3. At my request the following information may be disclosed and or used : *(specify dates where appropriate)*

- ☐ Immunizations *Date(s):*_____
- ☐ Medical Record *Date(s):*_____
- ☐ Medical Record (last two years)
- ☐ X-Ray Reports *Date(s):*_____
- ☐ X-Ray Films *Date(s):*_____
  (specify type) _____
- ☐ Laboratory Results *Date(s):*_____
- ☐ HIV/AIDS Test Results *Date(s):*_____
- ☐ Mental Health Record *Date(s):*_____
- ☐ Billing Record *Date(s):*_____
- ☐ Other Records *Date(s):*_____
  (specify type) _____

For the purpose of: *(check all that apply)*

- ☐ Continuity of Care
- ☐ Form Completion
- ☐ Eligibility/Enrollment
- ☐ Other (Specify) _____
- ☐ Personal Use
- ☐ Attorney Inquiry
- ☐ Rate Setting
- ☐ Consultation
- ☐ Social Security
- ☐ Employer Request
- ☐ Insurance Claim
- ☐ Workers' Comp
- ☐ Appeals

Signature and date must be on Page 2 for this authorization to be valid.

Revised 5/16/03; 1/01/04; 4/30/08

Patient Name:
Kaiser Medical Record No.:
Date of Birth:

4. I understand that the information released upon authority of this authorization may include information concerning treatment of physical and mental illness, alcohol/drug abuse, HIV/AIDS test results, diagnoses or treatment of HIV/AIDS, and past medical history information.

5. This authorization will expire one (1) year from the date of signing. I understand that I have a right to revoke this authorization in writing at any time and must submit my written revocation to Kaiser Permanente, Medical Correspondence, 5410 Lancaster Drive, Brooklyn Heights, OH 44131. I understand that the revocation will not apply to any actions taken in reliance on this authorization. Revocation of an authorization used to secure a policy of insurance, including health insurance from a Kaiser Permanente entity, may not be permitted during the period of time the insurer may contest the policy issued or a claim under the policy

6. I understand that Kaiser Permanente may not condition treatment, payment, enrollment in the health plan, or eligibility for benefits on my execution of this authorization, except when Kaiser Permanente seeks authorization (1) because it is providing research-related treatment; (2) for purposes of determining health plan eligibility, enrollment underwriting, or risk rating, so long as the authorization is not for use or disclosure of HIPAA psychotherapy notes; or (3) because it is providing treatment solely for the purpose of creating protected health information for the disclosure to a third party.

7. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure by the recipient and is not protected by the KP policy or the HIPAA Privacy Rule.

8. Kaiser Foundation Health Plan of Ohio and The Ohio Permanente Medical Group contract with a copy service authorized to duplicate records and process requests for medical records. I understand that a reasonable fee may be charged for duplication of records and accept full financial responsibility for that fee.

9. I understand that I (or person authorized to act as my representative) am entitled to receive a copy of this authorization.

By signing this form below, you are authorizing the release of the requested information identified above. If the person signing is not the member/patient indicate the relationship to the member/patient and attach supporting authorization or legal documentation.

_____ _____

Signature of Patient or Authorized Personal Representative Date

_____ _____

Authorized Personal Representative's Name Relationship to Patient

Signature and date must be on Page 2 for this authorization to be valid.

Revised 5/16/03; 1/01/04; 4/30/08

(1) Authorized Personal Representative is a person who has legal authority to act for an individual in making decisions related to the individual's health care or for a deceased individual or the deceased's estate. The personal representative can be a person who has been designated by the individual (e.g., Power of Attorney) or otherwise has legal authority (e.g., by operation of law, such as a parent; by court appointment).