KAISER PERMANENTE®

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

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize:

Name of sending person/organization

Street Address

City State Zip Code

Telephone Number

Records and information pertaining to:

Name of Member/Patient (List other names used) Date of Birth (MM/DD/YYYY)

Medical Record Number / Group # Daytime Phone Number

Street Address

City State Zip Code

To disclose to:

Recipient Name

Street Address

City State Zip Code

Distribution:

- ❑ Fax Number _____
- ❑ Mail to Address Above
- ❑ Pick up

Media Type:

- ❑ Paper
- ❑ Electronic _____

I am requesting: ❑ My records ❑ Records for a Child / Adult for whom I am a legal guardian or personal representative

Specify Records to be Released: (If date below is left blank, three year period will be disclosed.)

- ❑ General Medical Information (from _____ to _____)
- ❑ Immunizations (from _____ to _____)
- ❑ Form
- ❑ Laboratory Results (date) _____ Name or Type of Test(s): _____
- ❑ Radiology Images (exams/dates) _____
- ❑ Copay Summary for ❑ Pharmacy ❑ Office Visits Calendar Year(s): _____
- ❑ Behavioral Health Records (from _____ to _____) Signature _____ Date _____
- ❑ Sexually Transmitted Disease (from _____ to _____) Signature _____ Date _____
- ❑ Alcohol/Drug Records (from _____ to _____) Signature _____ Date _____
- ❑ HIV/AIDS/ARC Records (from _____ to _____) Signature _____ Date _____
- ❑ Other Records (specify): _____

Recipient Use: Please describe each purpose of the requested use or disclosure of the health information:
❑ Personal Copy ❑ Continuity of Care ❑ Insurance ❑ Legal/Attorney ❑ Workers' Compensation ❑ Other: _____

Duration: This authorization will remain valid for one year from the date of your signature.

Revocation: 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.

Redisclosure: 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 164.500 and 42 CFR Part 2.

Conditions: Kaiser Permanente may not condition treatment, payment, enrollment or eligibility for benefits on my providing or refusing to provide this authorization. **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.

A copy of this authorization is valid as an original. Member/patient has a right to a copy of this authorization.

Date Signature If Signed by Other than Member/Patient, Indicate Relationship

PAYMENT MAY BE REQUIRED BEFORE WE CAN COMPLETE THIS REQUEST

Signature Date