

Patient Name: _____
 MRN: _____ Date of Birth: _____
 Address: _____
 City: _____
 State: _____ Zip Code: _____
 Telephone Number: _____
 Email: _____

**AUTHORIZATION FOR USE OR
DISCLOSURE OF HEALTH INFORMATION**

Note: Fees may apply to certain requests

Kaiser Permanente will not condition treatment, payment, enrollment or eligibility for benefits on providing or refusing to provide this authorization.

This authorizes Kaiser Permanente Medical Center(s): _____

Kaiser Permanente may disclose this information to:

- To: Disclose a copy of medical records as specified below
 Complete form(s) (see PURPOSE below)
 Allow named KP physician to view records

or their representative:
PROFESSIONAL SERVICES
 P.O. Box 3366
 Santa Rosa, CA 95402
 (707) 546-0825
 info@copyservice.net

PURPOSE: The health information disclosed may only be used for the following purposes: _____

CAREFULLY SPECIFY HEALTH INFORMATION TO BE RELEASED FOR USE AND DISCLOSURE

- Hospital Records from _____ to _____
 Medical Office Records from _____ to _____

NOTE: Hospital and medical office records may include information related to mental health, alcohol/drug, and HIV references. The actual treatment records from mental health and/or alcohol/drug departments, and/or results of HIV tests will not be released unless specifically requested below.

- Specific Injury/Treatment: _____ Department: _____ from _____ to _____
 X-Ray: Images and/or Films Reports Describe: _____
 Laboratory Results from _____ to _____
 Other (specify): _____
 Protected Minor Records (Adolescent Confidential). Only applicable for patient requesters 12-17 years old.

SIGNATURES AND DATES REQUIRED IF ANY OF THE FOLLOWING BOXES ARE CHECKED

- Mental Health from _____ to _____ Signature: _____ Date: _____
 Alcohol / Drug from _____ to _____ Signature: _____ Date: _____
 HIV Test Results from _____ to _____ Signature: _____ Date: _____

Media Preference: Paper CD (if available electronically) N/A Delivery Preference: Mail Pickup Fax Email N/A

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

REVOCAATION: 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.

REDISCLASURE: Once this health information is disclosed, Kaiser Permanente is not responsible for how the recipient uses or further discloses it.

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

Date Signature If not patient print your name and relationship