Mail [ ] Pick-up [ ]

KAISER PERMANENTE®

AUTHORIZATION TO RELEASE/OBTAIN PROTECTED HEALTH INFORMATION

1. I AUTHORIZE:

_____
Name of sending person/organization

_____
Street Address

_____
City State Zip Code

2. TO RELEASE TO:

_____
Name of receiving person/organization

_____
Street Address

_____
City State Zip Code

I authorize the disclosure of my health and/or payment information (Protected Health Information) noted below:
(Check all that apply)

☐ Attached Document ☐ Immunization Records Only ☐ **Entire record** for past three years (except for privileged information that requires a more specific authorization).
☐ Lab report(s): Date(s) _____
☐ X-ray report(s): Date(s) _____
☐ Billing, Claims, and Payment Information
☐ Other _____

☐ Confidential Communications: Start Date : _____ End Date: _____
(Both dates are required)

SPECIAL AUTHORIZATION: (Check all that apply)
By signing below, you are authorizing Kaiser Permanente to release information regarding:
☐ HIV/AIDS ☐ Drug and alcohol records ☐ Behavioral Health records
The information release may include treatment summaries, progress notes, test results, verbal exchange between treating practitioners or facilities.
Other: _____
Unless otherwise specified below, I understand that this special authorization shall expire 90 days from the request date. I request that this special authorization expire on (specify date or event): _____.

Signature: _____ Date: _____

Reason for Disclosure:
☐ Continuity of Care ☐ Personal Use ☐ Consultation ☐ Insurance Claim ☐ Employer Request ☐ Underwriting
☐ Form Completion ☐ Attorney Inquiry ☐ Social Security ☐ Workers' Comp
To resolve issues relating to the following claims (specify) _____
Other (specify) _____

(Continued on page 2)

AUTHORIZATION TO RELEASE/OBTAIN PROTECTED HEALTH INFORMATION

Name: _____

HRN: _____

- I understand that Kaiser Permanente cannot condition treatment, payment, enrollment in the health plan, or eligibility for benefits on obtaining a authorization, except for research related treatment, or if the only purpose of the health care is to create Protected Health Information for disclosure to a third party. I further understand that Kaiser Permanente can condition enrollment in the health plan or eligibility for benefits on obtaining a authorization before enrollment, provided that the authorization is necessary for Kaiser Permanente to make enrollment, eligibility, underwriting, or risk rating determinations, and not for the use or disclosure of psychotherapy notes.
- I understand that I (or the person authorized to act on my behalf) is entitled to receive a copy of this authorization.
- I understand that I may inspect my records and that a reasonable fee may be charged for the duplication of records. An estimate of charges will be provided upon request before duplication.
- I understand that Protected Health Information disclosed to others is no longer protected by Kaiser Permanente policy or the Health Insurance Portability and Accountability Act of 1996.
- I am aware of the consequences that may occur as a result of my signing this authorization request or my denial to do so.
- I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken based on this authorization. Send written revocation notice to: Kaiser Foundation Health Plan of Georgia, Inc., Member Services, Nine Piedmont Center, 3495 Piedmont Road, Atlanta, Georgia 30305. I further understand that the revocation of an authorization used to secure a policy of insurance, including health coverage from Kaiser Permanente, is not permitted during the period of time the insurer may contest the policy issued or a claim under the policy.
- Unless otherwise specified below, I understand that this authorization shall expire 90 days from the request date. I request that this authorization expire on (specify date or event): _____.

By signing below you are hereby authorizing Kaiser Permanente to request/release the requested information identified above.

_____	_____	_____
Patient's Name (At time of treatment) (Printed)	KP Health Record Number	Date of Birth
_____	_____	_____
If Minor – Date When Minor Legally Becomes An Adult	Patient/Legal Representative's Name (Printed)	Relationship to Patient
_____	_____	_____
Signature	Daytime Phone Number	Date

NOTE TO RECEIVING PERSON/PARTY: If this release pertains to alcohol or drug abuse information, please note that: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulation (42C F.R. Part 2) prohibits you from making further disclosure of it without the specific written consent of the patient to whom it pertains or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.