KAISER PERMANENTE®

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

Act for a Family Member via *Kaiser Permanente.org (Kp.org)* Access Authorization Form

Diminished Capacity Individual's Information:
I authorize Kaiser Permanente Foundation Health Plan and/or The Mid-Atlantic Permanente Medical Group, Inc. to disclose protected health information via Kaiser Permanante.org for the patient named below:

Patient Name: _____ Medical Record #:_____

Address: _____

City/State/Zipcode: _____

Telephone #: (___) _____ Patient's Date of Birth

Designated Proxy (Legal Representative) Information:
I authorize Kaiser Permanente Foundation Health Plan and/or The Mid-Atlantic Permanente Medical Group, Inc. to disclose protected health information on Kaiser Permanante.org for the patient named below:

_____ _____
Name of Person to Have Access Kaiser Medical Record Number

Date of Birth: Telephone #: (_____)_____

Relationship to Patient: ☐ Legal Guardian** ☐ Durable Power of Attorney for Health ☐ HealthCare Agent Form

**If the Legal Guardian, Durable Power of Attorney for Health Care or a Healthcare Agent, a copy of the supporting documentation must be attached to this form

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Patient or Patient's authorized legal representative must sign below
I understand that the information released upon authority of this authorization may include information regarding the patient's treatment for physical and mental illness, alcohol/drug abuse, HIV/AIDS test results, diagnosis or treatment of HIV/AIDS, and past medical history information. I understand that I may discontinue online Act for a Family Member access at any time by contacting the Health Information Management Services Department at any Medical Center in the Mid-Atlantic. For this authorization to be valid, activation of the Act for a Family Member online access feature must occur within 60 days from the date of signing this authorization form. I understand that this authorization shall be valid for a period not to exceed two (2) years. This authorization may also be revoked at anytime in writing.

_____ _____
Signature of Patient or Authorized Legal Representative Date

Return completed form and supporting legal documentation (if applicable) to:
Kaiser Permanente
Health Information Management Services Department

**********For Kaiser Permanente Internal Use Only**********

☐ Approved – Diminished Capacity Patient ☐ Not Approved – Patient does not have diminished capacity

Verified by Primary Care Physician Name:_____ Date:_____

Processed by: _____ Date Completed: _____