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Instructions***Patient self-request for prescription dispensing records***

- Complete **Authorization for Use and Disclosure of Pharmacy Information** on Page 2
- Patient must date and sign the authorization form

If the request is from an individual other than patient

- Individual must date, sign, and indicate relationship to the patients on the authorization form
- Individual must also include evidence of the legal authority to act on behalf of the patient along with the form. Evidence includes, but not limited to:
  - Letters of Guardianship
  - Letters of Conservatorship
  - Power of Attorney
  - Death Certificate

Submit completed form and fee, if applicable, by mail (fax copies not accepted) to:

Kaiser Permanente  
Pharmacy Informatics  
PO Box 5075  
Livermore, CA 94551-5075

***Third Party Requests (i.e. law firms, housing developments, etc)***

- Complete **Authorization for Use and Disclosure of Pharmacy Information** on Page 2
- Patient must date and sign the authorization form
- Third Party must also include evidence of legal authority to act on behalf of the patient along with the form. Evidence includes, but limited to:
  - Notice that individual has retained Third Party's services on the company letter head

Third party requests may be sent to:

Kaiser Permanente  
Pharmacy Records Request Desk  
12254 Bellflower Blvd  
Downey, CA 90242

Subpoenas and court orders must be served in person to the Pharmacy Custodian of Records at the address listed above.

Fees:

- **NCAL:** Request for records up to the past 30 months is available as a courtesy. Records beyond 30 months are assessed a service fee of \$15.00 per request / per member / patient. Enclose check or Money order made to the order of: Kaiser Foundation Hospitals (KFH). DO NOT SEND CASH.
- **SCAL:** Request for records up to the past 36 months is available as a courtesy. Records beyond 36 months are assessed a service fee of \$15.00 per request / per member / patient. Enclose check or Money order made to the order of: Kaiser Foundation Hospitals (KFH). DO NOT SEND CASH.



# AUTHORIZATION FOR USE AND DISCLOSURE OF PHARMACY INFORMATION

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

<b>Patient Information:</b>		Member's Region
Print Name of Patient	Medical Record Number	<input type="checkbox"/> Northern California
Address	Date of Birth	<input type="checkbox"/> Southern California
City State Zip	Email	Telephone Number

I hereby authorize: Kaiser Permanente Pharmacy, and / or Kaiser Foundation Health Plan Pharmacy, and / or Kaiser Foundation Hospital Pharmacy to disclose to:

Print Name of Recipient \_\_\_\_\_

Address \_\_\_\_\_

City State Zip \_\_\_\_\_

### SPECIFY THE PHARMACY INFORMATION TO BE USED OR DISCLOSED (mark all that apply):

- Pharmacy Records dated from \_\_\_\_\_ to \_\_\_\_\_
- Specific Drugs(s)/Medication(s) Records: \_\_\_\_\_ dated from \_\_\_\_\_ to \_\_\_\_\_
- Medical Expenses Detail Summary dated from \_\_\_\_\_ to \_\_\_\_\_
- Other (specify): \_\_\_\_\_

**NOTE: Pharmacy records including any information related to alcohol/drug treatment will not be disclosed unless specifically authorized below. SIGNATURE AND DATE IS REQUIRED IF BOX IS CHECKED.**

Alcohol / Drug dated from \_\_\_\_\_ to \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Media Type:  Electronic (Preferred)  Paper

Delivery Preference:  Email (Preferred) \_\_\_\_\_  Mail

**PURPOSE:** The pharmacy records and information disclosed may only be used for the following purpose(s): \_\_\_\_\_

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

**REVOCAION:** You or your personal representative can revoke this authorization upon written request. If you revoke, it will not affect information disclosed before the receipt of your written request to revoke.

**REDISCLASURE:** I understand that information disclosed pursuant to this authorization may no longer be protected under federal privacy law (HIPAA) and could be re-disclosed by the recipient. However, California law may prohibit the recipient's re-disclosure of my information.

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

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

<b>VERIFICATION OF SIGNEE'S IDENTITY (For Internal Use Only)</b>	Date:
The identity of the Member / Patient or Personal Representative was verified using the attached:	
<input type="checkbox"/> Driver's License	<input type="checkbox"/> Other Photo Identification
<input type="checkbox"/> Notarized Document	<input type="checkbox"/> Other
The legal authority of Personal Representative (if applicable) was verified using the attached:	
<input type="checkbox"/> Letters of Guardianship	<input type="checkbox"/> Letters of Conservatorship
<input type="checkbox"/> Power of Attorney	<input type="checkbox"/> Other