KAISER PERMANENTE®

All plans offered and underwritten by Kaiser Foundation Health Plan of the Northwest.
500 NE Multnomah St., Suite 100, Portland, OR 97232.

PATIENT:		
NICKNAME/MAIDEN NAME/OTHER:		
HEALTH RECORD NO.:		
DOB:	PHONE NO.:	
ADDRESS STREET OR BOX NUMBER:		
CITY:	STATE:	ZIP+4:

Consent to Verbally Disclose Protected Health Information to Family Members and Friends

1. I consent for Kaiser Permanente to discuss/share protected health information about me with the following individual(s) who are involved in my care:

NAME:	RELATIONSHIP:	PHONE NO.:
NAME:	RELATIONSHIP:	PHONE NO.:
NAME:	RELATIONSHIP:	PHONE NO.:

2. Type of information to be shared or disclosed:
   - ☐ Appointment information
   - ☐ Prescription information
   - ☐ All information (including psychiatric consults and mental illness, developmental disabilities, genetic testing, HIV/AIDS and test results, sexually transmitted infection, and/or reproductive care, if applicable) excluding substance use disorder

3. I consent that Kaiser Permanente may leave detailed phone messages about my medical and health plan information with the following:
   - ☐ Voicemail
   - ☐ Person answering

This consent shall remain in effect until revoked in writing by the member/patient. Submitting a new form will revoke existing form. If this consent is signed by a minor, it will automatically expire when the minor reaches the age of 18 years old. (Oregon or Washington Confidential Communication Request forms may override this form.)

X _____ _____

SIGNATURE OF PATIENT/AUTHORIZED INDIVIDUAL | DATE

Mail to: Health Information Files – Process Center, 10220 SE Sunnyside Road, Clackamas, Oregon, 97015

Fax to: 503-571-5877

Kaiser Permanente reserves the right to make disclosures otherwise permitted under HIPAA. This consent form does not authorize release of patient health records, which requires a HIPAA Authorization.

17805B 02/22 HIM/PRC HIM_Regional Forms Committee last reviewed_02-10-22

Scan: Doc type "Letter" **HealthConnect Tab:** AD/ROI