KAISER PERMANENTE®

FORMAT OF DISCLOSURE AND INTENT TO PAY CHARGES RELATED TO AUTHORIZATION TO USE AND DISCLOSE REQUEST

Kaiser Foundation Health Plan of Georgia, Inc. and The Southeast Permanente Medical Group, Inc. ("Kaiser Permanente")

I have submitted to Kaiser Permanente an:

- **Authorization to Use and Disclose Protected Health Information;**
- **Authorization to Use and Disclose Psychotherapy Treatment Records; and/or**
- **Authorization to Use and Disclose Breast Imaging & Mammography Information.**

In order for Kaiser Permanente to fulfill my request, I must identify the format I wish for the information requested be disclosed to the recipient I identified in the authorization. With respect to the records that I have requested that Kaiser Permanente disclose on my behalf, I desire for disclosure to occur in the following format(s):

I would like for my records (including psychotherapy records if requested) to be disclosed in the following format(s) (does not including radiology or breast imaging & mammography information):

- Flash Drive
- CD
- Paper

(you may select more than one)

I would like for my radiology image records to be disclosed in the following format(s) (does not include breast imaging & mammography information records):

- DVD
- Film

(you may select more than one)

I would like for my breast imaging & mammography information records to be disclosed in the following manner:

- Permanent transfer of the original mammogram films to the facility listed in my "Authorization to Use and Disclose Breast Imaging & Mammography Information" request.
- Loan of these films for comparison and return to originating facility within thirty (30) days.

(select **only** one)

I understand that the original breast imaging & mammography films will be released and that no back up copies will be available. Once these films are released, I will be solely responsible for their disposition. By signing this form below, I release Kaiser Permanente of all liability with regard to the storage and disposition of these films.

I understand that in order to complete and fulfill my request, charges may apply and pursuant to O.C.G.A. §31-33-3, payment for all requested information is due prior to release/disclosure. Kaiser Permanente will not be able to process my authorization to use and disclose form without my agreement to pay (no fee applies to records requested in order to make or complete an application for a disability benefits program, in which case this form is applicable only to format of disclosure selections).

If you would like to view our fee schedule, you may view it in the Forms and Publications page under the Locate Our Services tab of the home page (kp.org) or at your medical office.

I wish to pre-approve the cost of my request (I will be contacted with a cost estimate) **Yes** **No**
I will be paying by **check or** **credit card** (I will be contacted when my information is ready)**.**

By signing below, I agree to pay all applicable charges relating to completion and fulfillment of my request for release of my health information or that of the individual for whom I am a parent or personal representative. Further, with respect to breast imaging and mammography records if disclosure is requested, I release Kaiser Permanente from any and all liability resulting from the handling and storage of these films following their disclosure.

_____ _____ _____

Date Signature of Patient or Personal Representative Indicate Relationship (if Signed by Other than Patient)