KAISER PERMANENTE®

Kaiser Permanente Insurance Company

AUTHORIZATION FOR USE OR DISCLOSURE OF PATIENT HEALTH INFORMATION

Note: Fees may apply to certain requests

Patient Name: _____

Kaiser # _____ Date of Birth: _____

Address: _____

City: _____

State: _____ Zip Code: _____

Telephone Number: ( ) _____

Email: _____

Providers named herein will not condition treatment, payment, enrollment or eligibility for benefits on providing, or refusing to provide this authorization.

This authorizes the following Providers including Kaiser Permanente Medical Center(s): _____

To:
- ☐ Produce a copy of medical records as specified below
- ☐ Complete form(s) (Please specify form type(s) in the PURPOSE section below)
- ☐ Allow named physician to view records

Provider(s) may disclose this information to:

Recipient Name: Laura Cross (filice Insurance)

Address: 1150 Moraga Way

City: Moraga

State: CA Zip Code: _____

Telephone number: (925) 385-5305

Fax number: ( ) _____

Email: laura@filice.com

PURPOSE: The health information disclosed may only be used for the following purposes: _____

FOR COPIES, SPECIFY THE HEALTH INFORMATION NEEDED FOR USE OR DISCLOSURE

☐ Medical Office Records dated from _____ to _____

☐ Hospital Records dated from _____ to _____

NOTE: Hospital and medical office records may include information related to mental health, alcohol/drug, and HIV references. The actual treatment records from mental health and/or alcohol/drug departments, and/or results of HIV tests will not be disclosed unless specifically requested below.

SIGNATURES AND DATES REQUIRED IF ANY OF THE FOLLOWING BOXES ARE CHECKED

☐ Mental Health dated from _____ to _____ Signature: _____ Date: _____

☐ Alcohol / Drug dated from _____ to _____ Signature: _____ Date: _____

☐ HIV Test Results dated from _____ to _____ Signature: _____ Date: _____

☐ Specific Injury/Treatment: _____ Department: _____ dated from _____ to _____

☐ X-Ray: ☐ Images and/or Films ☐ Reports Describe: _____

☐ Laboratory Results dated from _____ to _____

☐ Other (specify): _____

☐ Protected Minor Records (Adolescent Confidential). Only applicable for patient requesters 12-17 years old.

Media Preference: ☐ Paper ☐ CD (if available electronically) **Delivery Preference:** ☐ Mail ☐ Pickup ☐ Fax ☑ Email

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

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

REDISCLOSURE: Once this health information is disclosed, how the recipient further discloses it may no longer be protected under federal privacy law (HIPAA).

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

_____ _____ _____

Date Signature If not patient, print your name and relationship