KAISER PERMANENTE®

AUTHORIZATION FOR USE AND DISCLOSURE OF PHARMACY PRESCRIPTION INFORMATION

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

I hereby authorize: Kaiser Permanente Pharmacy (KFH and/or KFHP):

To disclose to:

Print Name of Recipient

Address

City State Zip

My prescription records/information:

Print Name of Member / Patient

Medical Record Number

Date of Birth

SPECIFY THE PRESCRIPTION INFORMATION TO BE USED OR DISCLOSED:

- ☐ All pharmacy records dated from: _____ to _____
- ☐ Record of a specific prescription: _____ dated from _____ to _____
- ☐ Protected Minor Records (Adolescent Confidential). Only applicable if member / patient is 12-17 years old.
- ☐ Medical Expense Detail ("Tax Summary") dated from _____ to _____
- ☐ Other (specify): _____

NOTE: Pharmacy records indicating treatment related to mental health, alcohol/drug treatment, HIV/AIDS status and/or genetic information will not be disclosed unless specifically authorized 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/AIDS Status dated from _____ to _____ Signature: _____ Date: _____
- ☐ Genetic Information dated from _____ to _____ Signature: _____ Date: _____

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).

REVOCATION: 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.

CHARGES: I understand that I may be charged reasonable clerical costs and that you may charge a copy or other fee associated with this request. I agree to pay these costs prior to receipt of the requested information.

REDISCLOSURE: 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

Mail or deliver form and copy of required documentation to: NPCO Records Desk, 12254 Bellflower Blvd, Downey CA 90242.

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