KAISER PERMANENTE®

Kaiser Foundation Hospitals
Southern California Permanente Medical Group

AUTHORIZATION FOR RELEASE AND / OR DISCLOSURE OF MEDICAL INFORMATION

IMPRINT KAISER PERMANENTE ID CARD HERE

Treatment, payment, enrollment or eligibility for benefits will not be conditioned on my providing or refusing to provide this authorization.

Please **REQUEST** Medical Information **FROM**:

Name of Health Care Provider

Name of Medical Office/Hospital

Street Address

City, State and Zip Code

Please **SEND** Medical Information **TO**: c/o RONSIN PHOTOCOPY INC

Name of Person or Entity to Receive Information

Title (Physician, Therapist, Attorney)

Street Address

City, State and Zip Code

I hereby authorize _____ to release and / or disclose the medical information as indicated below to the health care provider, entity, or person I have indicated above.

Release and / or disclose records and information regarding:

Name of Patient (List Other Names Used) | Medical Record Number | Date of Birth

Address | City | State | Zip Code | ( ) Telephone Number

DURATION: This authorization shall become effective immediately and shall remain in effect until _____(*enter date*) or for one year from the date of signature if no date entered.

REVOCATION: This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosing party. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received.

REDISCLOSURE: I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless disclosure is specifically required or permitted by law.

SPECIFY RECORDS TO BE RELEASED AND / OR DISCLOSED:

Check the box and initial which type of information is to be released and / or disclosed:

- ❑ **General Medical Information** *(from_____ to _____)*
- ❑ **Information Regarding Specific Injury or Treatment** *(from_____ to _____)*
- ❑ **X-Ray (check one or both):** ❑ **Films** ❑ **Reports**
- ❑ **Laboratory Results**
- ❑ **Mental Health** *(from_____ to _____)*
- ❑ **Alcohol / Drug** *(from_____ to _____)*
- ❑ **HIV Test Results** *(from_____ to _____)*
- ❑ **Other (specify):** _____

Signature of Patient or Patient's Representative | Date

Signature of Patient or Patient's Representative | Date

Signature of Patient or Patient's Representative | Date

I request that the health information released and / or disclosed pursuant to this authorization be used for the following purposes only: _____

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

Date | Signature of Patient or Patient's Representative | Indicate Relationship (if Signed by Other than Patient)