I authorize Kaiser Permanente to release the following information for the purpose of:
_____
_____
_____
Description of information to be used/disclosed (Be as specific as possible):
☞ All records related to (describe):
_____
☞ X-ray films
(describe):_____
☞ Other (describe):
_____
Please send my protected health information to:
_____
NAME OF PERSON TO RECEIVE INFORMATION
_____
TITLE (PHYSICIAN, ATTORNEY, ETC.) PHONE NUMBER
_____
STREET ADDRESS
_____
CITY STATE ZIP CODE
If the information to be used/disclosed contains any of the types of records or information listed below, additional laws relating to
the use and disclosure of the information may apply. I understand and agree that this information will be used or disclosed if I
place my initials in the applicable space next to the type of information:
_____Drug/Alcohol diagnosis, treatment or referral information
_____Mental Health information
_____HIV/AIDS information
_____Genetic testing information
I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be
protected under federal law. However, I also understand that federal or state law may restrict redisclosure of drug/alcohol diagnosis,
treatment or referral information, mental health information and genetic testing information.
You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health
care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care
service is if the health care services are solely for the purpose of providing health information to someone else and the authorization
is necessary to make that disclosure.
You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may
no longer be used or disclosed for the purposes described in this written authorization. Any use or disclosure already made with
your permission cannot be undone. To revoke this authorization, please send a written statement to Kaiser Permanente, Medical
Reports Department at 10220 SE Sunnyside Rd., Clackamas, Oregon 97015 and state that you are revoking this authorization.
I have read this authorization and I understand it. Unless revoked, this authorization expires within 12 months in Oregon and 90
days in Washington.
X_____
X_____
SIGNATURE OF INDIVIDUAL OR PERSONAL REPRESENTATIVE DATE

X_____ Identity/Authority verified

DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY
Kaiser Foundation Health Plan of the Northwest • Kaiser Foundation Hospitals
Kaiser Permanente Health Alternatives

Authorization for Kaiser Permanente to Use/Disclose Protected Health Information

PATIENT
NICKNAME / MAIDEN NAME / OTHER SOCIAL SECURITY
HEALTH RECORD NO.
DATE OF BIRTH: (MO/DAY/YR) PHONE NUMBER
( )
ADDRESS STREET OR BX NUMBER
CITY STATE ZIP + 4

ASSIGNMENT OF BENEFITS: FOR USE BY INSURANCE CLAIMS DEPARTMENT ONLY

My signature below authorizes payment by my insurer to the physician/hospital on benefits due to me but not to exceed the balance of my account.

X _____

X_____

SIGNATURE OF INDIVIDUAL OR PERSONAL REPRESENTATIVE DATE

AUTHORIZATION FOR KAISER PERMANENTE TO RELEASE MEDICAL INFORMATION

0004-1756 4-03 Medical Reports/PC File: OPMR : Scan Photocopy to patient

If returning this Authorization to
Kaiser Permanente, send to:

Medical Reports
10220 SE Sunnyside Rd
Clackamas, Oregon 97015