KAISER PERMANENTE®

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 NO.	
HEALTH RECORD NO.		
DATE OF BIRTH: (MO/DAY/YR)	PHONE NUMBER ( )	
ADDRESS	STREET OR BOX NO.	
CITY	STATE	ZIP + 4

SEE REVERSE SIDE FOR MAILING INSTRUCTIONS

AUTHORIZATION FOR KAISER PERMANENTE TO RELEASE MEDICAL INFORMATION

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
- ☐ X-ray films (describe): _____
- ☐ Other (describe): _____

Please send my protected health information to:

PROTECTIVE LIFE INSURANCE COMPANY
2801 Highway 280 South
Birmingham, Alabama 35223

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 - including provider notes
_____ 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. For Drug and Alcohol records, you may revoke this authorization orally or 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, Release of Information Department at 10220 SE Sunnyside Rd., Clackamas, Oregon 97015 and state that you are revoking this authorization. To revoke this authorization orally, please call Release of Information at 503-571-5051 and state that you are orally 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

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

Instructions to patient:

1. **Complete reverse side of form authorizing Kaiser Permanente to release your medical records.**

2. **Provide complete name and mailing address where your records are to be sent.**

3. **Return to:**

   Release of Information Department
   Kaiser Permanente
   10220 S.E. Sunnyside Road
   Clackamas, OR 97015-9764