



Kaiser Foundation Health Plan, Inc.  
Kaiser Foundation Hospitals  
The Permanente Medical Group, Inc.

**AUTHORIZATION FOR USE AND/OR DISCLOSURE OF MEMBER/PATIENT HEALTH INFORMATION**

IMPRINT AREA

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

**I hereby authorize:**

**to disclose to:**

Name of Disclosing Party

Name of Recipient

Address

Address

City

State

ZIP

City

State

ZIP

**records and information pertaining to:**

Name of Member/Patient (List Other Names Used)

Medical Record Number

Date of Birth

Address

Telephone Number

**DURATION:** This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here \_\_\_\_\_ (Date).

**REVOCAION:** This authorization is also subject to written revocation by the member/patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization.

**REDIS-CLOSURE:** I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

**SPECIFY** Check the box, initial and/or sign to specify which type of information is to be disclosed.

**RECORDS:**  **MEDICAL INFORMATION**

\_\_\_\_\_ (Initial)

**PSYCHIATRIC INFORMATION**

Signature

Date

**DRUG/ALCOHOL INFORMATION**

Signature

Date

**RESULTS OF AN HIV TEST**

Signature

Date

**GENETIC RECORDS**

Signature

Date

**OTHER HEALTH INFORMATION**

\_\_\_\_\_ (Initial) (specify below)

Specify the records to be disclosed: \_\_\_\_\_

The recipient may use the health information authorized on this form for the following purposes: \_\_\_\_\_

A copy of this authorization is as valid as the original.

Member/Patient has a right to a copy of this authorization.

Date

Signature

If Signed by Other than Member/Patient, Indicate Relationship