



MR #: \_\_\_\_\_

Name: \_\_\_\_\_

### 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: Kaiser Permanente Medical Center  
Attn: Outpatient Medical Records**

\_\_\_\_\_  
Name of Disclosing Party

\_\_\_\_\_  
Name of Recipient

\_\_\_\_\_  
Address

**401 Bicentennial Way**

\_\_\_\_\_  
Address

\_\_\_\_\_  
City State ZIP

**Santa Rosa California 95403**

\_\_\_\_\_  
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).

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

- MEDICAL INFORMATION**
- PSYCHIATRIC INFORMATION**
- DRUG/ALCOHOL INFORMATION**
- RESULTS OF AN HIV TEST**
- GENETIC RECORDS**
- OTHER HEALTH INFORMATION**

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

\_\_\_\_\_  
Signature Date

\_\_\_\_\_  
Signature Date

\_\_\_\_\_  
Signature Date

\_\_\_\_\_  
Signature Date

\_\_\_\_\_  
(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