



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 \_\_\_\_\_

NAME OF DISCLOSING PARTY

ADDRESS

CITY

STATE

ZIP

to disclose to

NAME OF RECIPIENT

ADDRESS

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 \_\_\_\_\_.

**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.

**REDISCLASURE:**

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 and initial to specify which type of information is to be disclosed.

**MEDICAL INFORMATION** \_\_\_\_\_  
INITIAL

**PSYCHIATRIC INFORMATION**

\_\_\_\_\_  
SIGNATURE DATE

**DRUG/ALCOHOL INFORMATION**

\_\_\_\_\_  
SIGNATURE DATE

**RESULTS OF AN HIV BLOOD TEST**

\_\_\_\_\_  
SIGNATURE DATE

**OTHER HEALTH INFORMATION** \_\_\_\_\_ (specify below)  
INITIAL

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

If signed by other than member/patient, indicate relationship: \_\_\_\_\_