KAISER PERMANENTE®

Kaiser Foundation Health Plan of Washington

Designation of Individuals Involved in Care

DATE		
MEMBER / PATIENT NAME		
MEDICAL RECORD NUMBER		
DOB (MM/DD/YYYY)	PHONE NO.: ( )	
ADDRESS STREET OR BOX NUMBER:		
CITY:	STATE:	ZIP+4:

You have the right to identify individuals other than your health care providers who are involved in your care (family, friends, or others). We may verbally release your medical information to an individual you have identified as involved in your medical care. We may also give information to someone who helps pay for your care. Kaiser Permanente will only share your health information with the individuals you designate, except as required or permitted by law. To update your designees, please complete a new form. Submitting a new form will revoke (cancel) all previous forms.

I designate the following people as involved in my care and authorize Kaiser Permanente to verbally disclose the information I've specified to these individuals:

NAME:	RELATIONSHIP:	PHONE NO.:
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NAME:	RELATIONSHIP:	PHONE NO:

1. **Type of information to be shared or disclosed:**

   - ❑ ALL information (including psychiatric consults and mental illness, developmental disabilities, genetic testing, HIV/AIDS and test results, sexually transmitted infection, and/or reproductive care if applicable) excluding substance abuse disorder
   - ❑ Health Plan information (billing, benefits, authorizations) including updating demographics and other information
   - ❑ Specific information listed here: _____

2. **I permit Kaiser Permanente to leave detailed phone messages about my medical and health plan information with the following:**

   - ❑ Voicemail at this phone number: _____
   - ❑ Person(s) listed above who answer

3. **These designations will remain in effect until (add expiration date or event) _____ or until revoked by me in writing or a new form is submitted. If signed by a minor, this form will automatically expire when the minor reaches the age of 18 years old. (Washington Confidential Communication Request forms may override this form.)**

X _____ _____

If signed by a personal representative of the patient, please complete the following — Date

Personal Representative's Name: _____

Relationship to Patient: ❑ Parent ❑ Legal Guardian* ❑ Holder of a Medical Power of Attorney*

*Please attach Legal Documentation if you are the Legal Guardian or Holder of Power of Attorney

Scan: Designation of Individuals Involved in Care Original to Scanning ACN-AC3 or Scanning RCS. Copy to patient.

