



(\*Kaiser Permanente regions are listed on reverse side of this form)

See reverse side for instructions to fill out this form.  
Failure to follow instructions may result in processing delay.

## Authorization for use or disclosure of patient health information

Note: Fees may apply to certain requests

### 1. PATIENT INFORMATION

PRINT Patient Name: \_\_\_\_\_  
Birth Date (mm/dd/yyyy): \_\_\_\_\_  
Medical Record Number: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone #: \_\_\_\_\_  
Email: \_\_\_\_\_

### 2. KAISER PERMANENTE MAY RELEASE THIS INFORMATION TO:

☐ Check if the same as 1 above

Organization or person: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Email: \_\_\_\_\_

**DELIVERY METHOD FOR RECORDS:** ☐ Secure Email ☐ Fax ☐ Patient account at kp.org/wa (patients only)

### 3. PURPOSE OF RELEASE:

☐ Doctor ☐ Legal ☐ Insurance ☐ Medical Leave ☐ Personal / Other

### 4. INFORMATION TO BE RELEASED: FROM DATE \_\_\_\_/\_\_\_\_/\_\_\_\_ TO DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

- ☐ Medical records ☐ Radiology reports: \_\_\_\_\_  
☐ Immunizations ☐ Radiology images (on CD): \_\_\_\_\_  
☐ Billing records ☐ FMLA documentation  
☐ Other (provider, department, specialty): \_\_\_\_\_

### 5. PATIENT AUTHORIZATION: I understand that:

- ✓ Records released may include information regarding the testing, diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, chemical dependency or mental health and for patients below age 18, information regarding reproductive care. By signing this form, I give my specific authorization for this information to be released.
- ✓ Generally, an entity covered by the Health Insurance Portability and Accountability Act of 1996, may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. If this authorization is for purposes of determining enrollment, eligibility, underwriting or risk rating prior to enrollment, not signing or revoking this authorization may impact enrollment or benefit determinations.
- ✓ I may revoke this authorization in writing. If I revoke my authorization, it will not affect any actions already taken based upon this authorization.
- ✓ Once disclosed, health care information may be subject to redisclosure by the recipient and may no longer be protected under health information privacy laws.

### 6. SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

If personal representative\*, print name and relationship: \_\_\_\_\_

\*Documentation may be required to prove authority to sign on behalf of the patient.

### 7. MINOR SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

Signature of minor is required for certain information, see number 7 on instruction page.

### 8. This authorization expires one year from the date signed OR on the date or event indicated here:

**Business Office/Clinic Staff: Has this request been processed?**

WWA YES, already processed: send to Scanning at RCR-Scanning  
WWA NO, needs processing: fax to ROI at 877-848-6896

EWA YES, already processed: send to Scanning at ACN-AC3  
EWA NO, needs processing: fax to ROI at 855-414-1751

Please visit [kp.org](http://kp.org) for contact information for the following Kaiser Permanente regions:

- California
- Colorado
- Georgia
- Hawaii
- Mid-Atlantic States (Maryland, Virginia & Washington DC)
- Northwest (Oregon, Longview & Vancouver, Washington)
- Washington

## INSTRUCTIONS:

1. **PATIENT INFORMATION:** Print name of patient, birth date, medical record number (if known), address, phone number and email.
2. **RECIPIENT INFORMATION:** Print name, address, phone number, fax number and email address.  
**Delivery method:** Please PRINT the email address clearly  
**KP.ORG/WA** – records remain available for 90 days after they are released to your secure member account.
3. **PURPOSE:** Check the box that applies to the reason the records are being requested.
4. **INFORMATION TO BE RELEASED:** Indicate date(s) that are authorized to be released.
  - Medical records – a maximum of 10 years of records
  - Billing records – premium payments not included
  - Radiology images – please specify images and/or dates needed
  - Other – use this field to indicate specific information needed. Only that specific information will be released.
5. Read the **PATIENT AUTHORIZATION section**.
6. **SIGNATURE:** Sign and date. Electronic signatures must meet federal and state requirements. Personal representative should print name and indicate relationship to the patient. Documentation may be required to prove authority to sign on behalf of the patient.
7. **MINOR SIGNATURE:** Minor patients have the right to control certain types of healthcare information. They may be required to sign an authorization to release this information.
  - Sexually transmitted diseases including HIV (ages 14-17)
  - Mental health and addiction recovery services (ages 13-17)
  - Reproductive care (all minors)
8. **EXPIRATION:** If no date or event is given, authorization will expire one year from date signed.

To submit your request, please send your completed form to the appropriate locations listed below. Fax submission is preferred. Please visit our website [www.kp.org/wa](http://www.kp.org/wa) for additional copies of this form or for more information.

### Western Washington

Kaiser Foundation Health Plan of Washington  
Release of Information  
MAILSTOP: RCR-A3E-01  
PO Box 9010  
Renton, WA 98057-9010

Phone: 206-630-6848 or toll-free 1-866-656-4184  
Hours: 8 a.m. to 5 p.m.  
Email: [KPWA-ROI@kp.org](mailto:KPWA-ROI@kp.org)  
Fax: 877-848-6896

### Eastern Washington

Kaiser Foundation Health Plan of Washington  
Release of Information  
MAILSTOP: RFM-W200C2  
PO Box 204  
Spokane, WA 99210-0204

Phone: 509-241-7824  
Hours: 8 a.m. to 5 p.m.  
Email: [KPWA-ROI@kp.org](mailto:KPWA-ROI@kp.org)  
Fax: 855-414-1751

**To request Radiology Images ONLY (x-rays, MRI's, CT's, mammograms etc.), please send requests to:**

Kaiser Foundation Health Plan of Washington  
Central Imaging Center  
201 16th Ave E  
Seattle, WA 98112

Phone: 206-326-3715  
Email: [KPWA-RadROI@kp.org](mailto:KPWA-RadROI@kp.org)  
Fax: 855-524-2256