KAISER PERMANENTE®

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

AUTHORIZATION FOR USE OR DISCLOSURE OF PATIENT HEALTH INFORMATION

Note: Fees may apply to certain requests

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

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 FROM _____/_____/_____ TO _____/_____/_____ TO BE RELEASED:

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

5. PATIENT AUTHORIZATION: I understand that:

- ✓ Information released may include information regarding the testing, diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, chemical dependency or mental health and for patients ages 13-17, information regarding reproductive care. I give my specific authorization for this information to be released.
- ✓ Generally, Kaiser Foundation Health Plan of Washington and any other 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 by Kaiser Foundation Health Plan of Washington.
- ✓ 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 ages 13-17** 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 RCS	**EWA YES, already processed: send to Scanning at ACN-AC3**
WWA NO, needs processing: fax to ROI at 206-630-6849	**EWA NO, needs processing: fax to ROI at 509-232-3127**

Please visit 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 30 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:**
   - 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 ages 13 to 17 must authorize the release of information related to HIV/AIDS, sexually transmitted diseases, chemical dependency, mental health and reproductive care.
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** for additional copies of this form or for more information.

Western Washington
Kaiser Foundation Health Plan of Washington
Release of Information
MAILSTOP: RCG-D1N-02
PO Box 9812
Renton, WA 98057-9054

Phone: 206-630-6848 or toll-free 1-866-656-4184
Hours: 8 a.m. to 5 p.m.
Email: KPWA-ROI@kp.org
Fax: 206-630-6849

Eastern Washington
Kaiser Foundation Health Plan of Washington
Health Information Management
MAILSTOP: ACN-AC3
PO Box 204
Spokane, WA 99210-9809

Phone: 509-241-7824
Hours: 8 a.m. to 5 p.m.
Email: KPWA-ROI@kp.org
Fax: 509-232-3127

To request Radiology Images <u>ONLY</u> (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
Fax: 206-326-2007