Authorization to Disclose (Release) Health Care Information

KAISER PERMANENTE®

1 PATIENT INFORMATION: Birth Date _____ Member I.D. Number _____

PRINT Patient Name _____

Address _____

City, State, Zip _____

Daytime Telephone Number _____

2 INFORMATION TO BE RELEASED FROM (SELECT ONLY ONE):

☐ Kaiser Foundation Health Plan of Washington

☐ Organization, physician, or provider _____

Address _____

City, State, Zip _____

Phone _____ Fax _____

3 INFORMATION TO BE RELEASED TO: ☐ Check if the same as 1 above

Organization or person _____

Address _____

City, State, Zip _____

Phone _____ Fax _____

4 PURPOSE OF RELEASE:

☐ Legal ☐ Insurance ☐ Doctor ☐ Medical Leave ☐ Copies for personal use ☐ Other (Specify) _____

5 WHAT KIND OF INFORMATION DO YOU WANT RELEASED:

☐ **COPIES OF RECORDS AND/OR** ☐ **VERBAL COMMUNICATION**

(if neither box is checked, copies of records will be released)

☐ Medical Records from date **(YOU MUST INDICATE DATES)**: ___/___/___ to date: ___/___/___

☐ Specific Information (please specify): _____

☐ Billing Records (please specify): _____

☐ Diagnostic Images (please specify): _____

6 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/psychiatric illness and for patients age 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.

7 SIGNATURE: _____ DATE: ___/___/___

(Patient or Member, Guardian*, or Authorized Representative*).

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

8 MINOR SIGNATURE: _____ DATE: ___/___/___

(Signature of minor ages 13-17 is required for certain information, see number 8 on instruction page)

9 This authorization expires 90 days from the date signed OR on the date or event indicated here:

_____

10 DELIVERY PREFERENCE: ☐ Paper ☐ Compact Disk

☐ Electronic Delivery to patient** (patient email address required): _____

**This option is only available to patients only

Directions on next page

Staff Distribution: Western Washington to RCG-D1N-02 if processing still required, SRC for scanning if already processed; Eastern Washington to ACN-AC3 for processing and scanning

INSTRUCTIONS – This form is to be used if you have been treated at any Kaiser Foundation Health Plan of Washington Facility. Please follow instructions 1 through 10 to expedite processing your request. Thank you.

1. Print name of patient, birth date, Kaiser Permanente member identification number, address and daytime phone number for whom the medical records are being requested.
2. Check EITHER Kaiser Foundation Health Plan of Washington if the records are located at Kaiser Permanente or if located elsewhere, print the name of the physician, provider, or organization or person that is being asked to disclose copies of the records. If you are requesting records for treatment in other Kaiser Permanente regions, you should request records directly from the facility at which you were treated.
3. Print name, address and phone number of organization or person that is to receive the copies of the information.
4. Check the box that applies to the reason the records are being requested.
5. Check boxes to indicate what information is to be disclosed:
   a. Select the type of disclosure you're authorizing. Please mark for physical copies to be released and/or for verbal communication. For both options, please indicate the specific information you would like to be released.
   b. All inpatient, outpatient and ambulatory surgery visits for the specific time frame indicated.
   c. All records related to the course of treatment, diagnosis, procedure or condition indicated, form request, other.
   d. Billing Records
   e. Diagnostic images (please specify specific information) for example "all breast imaging" or "8/17/15 MRI" or "all head related 1990-1996", etc.
6. Read the patient authorization section.
7. Sign and indicate the date signed for patients ages 18 and older.
8. Minor patients have the legal right to consent to care and therefore the minor patient also controls the release of medical information generated in connection with their care. Minors between the ages of 13 and 17 must authorize the release of certain information concerning the minor: Chemical Dependency, Mental/psychiatric information; 14-17: HIV/Aids, sexually transmitted diseases, reproductive care including abortion services.
9. Indicate date for the authorization to expire if it is to be different than 90 days from date of signing.
10. Patients/members may receive a paper copy or an electronic copy in an electronic format that is readily producible for records currently stored in electronic form. Electronic copies are currently available on compact disk or via Secure Delivery Portal (email address required).

    Requests for Diagnostic Imaging CDs (x-rays, MRI scans, CT scans etc.) are processed through the Digital Imaging Library at the Central Imaging Center. If you are ONLY requesting digital images, send your request to the Central Imaging Center or contact them at the number below. There is no charge if you are requesting that digital images be sent directly to a non-Kaiser Permanente facility for your ongoing care. Charges may vary for personal copies. If you have questions regarding charges, the imaging library staff can provide an estimate.

Instructions can also be found on kp.org/wa

CHARGES

Kaiser Permanente patients and members can directly view and print some of their health information at the Kaiser Permanente member website which is accessible at **kp.org/wa**. The online record does not include certain hospital records, behavioral health records, or care you have gotten from providers who do not work at a Kaiser Permanente facility. There is no charge for copies of health information for a request made by a member or patient or their personal representative as determined by state law. There is also no charge if you have the copies sent directly to a health care facility or provider for continuing or transfer of care. Copies requested by other parties may be subject to a charge in accordance with Washington state law (WAC 246-08-400).

Contact the appropriate department listed below to request your copies of your medical record, for information about copy charges and/or questions related to copying health information from your Kaiser Permanente medical record. You can also find information at **kp.org/wa**.

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

Phone: 206-630-6848 or toll-free 1-866-656-4184
Fax: 206-630-6849
Hours: 8 a.m. – 5 p.m.

Eastern Washington
Kaiser Foundation Health Plan of Washington
Centralized Health Information Management
P.O. Box 204
Spokane, WA 99224

Phone: 509-241-7824
Fax: 509-232-3127
Hours: 8 a.m. – 5 p.m.

To request Diagnostic Imaging CD/DVD's <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

Kaiser Permanente Nondiscrimination Notice and Language Access Services

KAISER PERMANENTE®

KAISER PERMANENTE NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc. ("Kaiser Permanente") comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. Kaiser Permanente does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

Kaiser Permanente:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:
- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:
- Qualified interpreters
- Information written in other languages

If you need these services, contact Kaiser Permanente Member Services.

If you believe that Kaiser Permanente has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, you can file a grievance by phone, mail, fax, or email. If you need help filing a grievance, a Kaiser Permanente Member Services Representative is available to help you. Language assistance is provided free of charge.

Kaiser Permanente Member Services

Phone: 206-630-4636
Toll-free: 1-888-901-4636
TTY Washington Relay Service: 1-800-833-6388 or 711
TTY Idaho Relay Service: 1-800-377-3529 or 711
Fax: 206-901-6205 or toll-free 1-888-874-1765
Address: PO Box 34593, Seattle, WA 98124-1593
Email: csforms@ghc.org

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F
HHH Building
Washington, DC 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

For Medicare Advantage Plans Only: Kaiser Permanente is an HMO plan with a Medicare contract. Enrollment in Kaiser Permanente depends on contract renewal.

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LANGUAGE ACCESS SERVICES

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-888-901-4636 (TTY: 1-800-833-6388 or 711).

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

中文 **(Chinese)**：注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-901-4636 (TTY: 1-800-833-6388 / 711)。

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

한국어(Korean): 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-901-4636 (TTY: 1-800-833-6388 / 711) 번으로 전화해 주십시오.

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-901-4636 (телетайп: 1-800-833-6388 / 711).

Filipino (Tagalog): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

Українська (Ukrainian): УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-888-901-4636 (телетайп: 1-800-833-6388 / 711).

ភាសាខ្មែរ (Khmer)**៖ បរយ័ត៖** បើសិនអកនិយាខែរ, សេជំនួយែជក យេមិនគិតល គឺចនសំប់បំរេអក។ ចូរទូរស័ព 1-888-901-4636 (TTY: 1-800-833-6388 / 711)។

日本語 (Japanese): 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-901-4636 (TTY: 1-800-833-6388 / 711) まで、お電話にてご連絡ください。

አማርኛ (Amharic)፥ ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-888-901-4636 (መስማት ለተሳናቸው: 1-800-833-6388 / 711).

Oromiffa (Oromo): XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

العربية (Arabic): لديكم حق الحصول على مساعدة ومعلومات في ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-901-4636 (رقم هاتف الصم والبكم: 1-800-833-6388 / 711).

ਪੰਜਾਬੀ (Punjabi): ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-888-901-4636 (TTY: 1-800-833-6388 / 711) 'ਤੇ ਕਾਲ ਕਰੋ।

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

ພາສາລາວ (Lao): ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

Srpsko-hrvatski (Serbo-Croatian): OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-901-4636 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-800-833-6388 / 711).

Français (French): ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-901-4636 (ATS: 1-800-833-6388 / 711).

Română (Romanian): ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

Adamawa (Fulfulde): MAANDO: To a waawi Adamawa, e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

فارسی (Farsi): توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-888-901-4636 (TTY: 1-800-833-6388 / 711) تماس بگیرید.