



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:

to disclose to:

Name of Disclosing Party

Name of Recipient

Address

Address

City State ZIP

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 (Date).

REVOCAION: 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.

REDIS-CLOSURE: 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 Check the box, initial and/or sign to specify which type of information is to be disclosed.

- RECORDS: MEDICAL INFORMATION
PSYCHIATRIC INFORMATION
DRUG/ALCOHOL INFORMATION
RESULTS OF AN HIV TEST
GENETIC RECORDS
OTHER HEALTH INFORMATION

(Initial)

Signature Date

Signature Date

Signature Date

Signature Date

(Initial) (specify below)

Specify the records to be disclosed:

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

A copy of this authorization is as valid as the original.

Member/Patient has a right to a copy of this authorization.

Date

Signature

If Signed by Other than Member/Patient, Indicate Relationship