KAISER PERMANENTE®
Kaiser Foundation Hospitals
Southern California Permanente Medical Group

# AUTHORIZATION FOR RELEASE AND / OR DISCLOSURE OF MEDICAL INFORMATION

IMPRINT KAISER PERMANENTE ID CARD HERE

Treatment, payment, enrollment or eligibility for benefits will not be conditioned on my providing or refusing to provide this authorization.

Please **REQUEST** Medical Information **FROM**:

Name of Health Care Provider
SOUTHERN CALIFORNIA PERMANENTE MEDICAL GROUP
Name of Medical Office/Hospital
P.O. BOX 12099
Street Address
BAKERSFIELD, CA 93389
City, State and Zip Code

Please **SEND** Medical Information **TO**:

Name of Person or Entity to Receive Information
Title (Physician, Therapist, Attorney)
Street Address
City, State and Zip Code

**I hereby authorize** SCPMG **to release and / or disclose the medical information as indicated below to the health care provider, entity, or person I have indicated above.**

**Release and / or disclose records and information regarding:**

Name of Patient (List Other Names Used) | Medical Record Number | Date of Birth

Address | City | State | Zip Code | ( ) Telephone Number

**DURATION:** This authorization shall become effective immediately and shall remain in effect until_____ (*enter date*) or for one year from the date of signature if no date entered.

**REVOCATION:** This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosing party. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received.

**REDISCLOSURE:** I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless disclosure is specifically required or permitted by law. **However, once your information is disclosed outside of Kaiser Permanente, it may not be protected.**

**SPECIFY RECORDS TO BE RELEASED AND / OR DISCLOSED:**

**Check the box and initial which type of information is to be released and / or disclosed:**

- ☐ **General Medical Information (*from* _____ *to* _____). General Medical Records may include references or referrals to mental health treatment, if noted by my provider, but not the mental health records themselves, unless specifically requested below.**
- ☐ **Information Regarding Specific Injury or Treatment (*from* _____ *to* _____)**
- ☐ **Laboratory Results (*from* _____ *to* _____)**
- → ☐ **Mental Health (*from* _____ *to* _____)**
- → ☐ **Alcohol / Drug (*from* _____ *to* _____)**
- ☐ **HIV Test Results (*from* _____ *to* _____)**
- ☐ **Other (specify):** _____

BOTH LINES NEED TO BE SIGNED EVEN IF ONLY ONE APPLIES

Signature of Patient or Patient's Representative | Date

Signature of Patient or Patient's Representative | Date

Signature of Patient or Patient's Representative | Date

I request that the health information released and / or disclosed pursuant to this authorization be used for the following purposes only: _____

A copy of this authorization is valid as an original. I have the right to receive a copy of this authorization. The copy is for me to keep.

Date | Signature of Patient or Patient's Representative | Indicate Relationship (if Signed by Other than Patient)