SF 4400-KHI (5-2003)

KAISER PERMANENTE®
Kaiser Foundation Hospitals
The Permanente Medical Group, Inc.

Copies of this signed authorization
Will be considered as valid as the original.

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF MEMBER/PATIENT HEALTH INFORMATION

Name: _____

MR#: : _____

IMPRINT AREA

Neither treatment, payment, enrollment, or eligibility for benefits will be conditioned on my providing or refusing to provide this authorization.

I hereby authorize _____
NAME OF DISCLOSING PARTY

_____
ADDRESS

_____
CITY STATE ZIP

to disclose to _____
NAME OF RECEIVING PARTY

_____
ADDRESS

_____
CITY STATE ZIP

records and information pertaining to

_____ _____ _____
NAME OF 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 until _____ DATE
Or for one year from the date of signature.

REVOCATION: This Authorization is also subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party. My written revocation will be effective upon receipt, but will not be effective to the extent that the Requester or others have acted in reliance upon this Authorization.

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 such use or disclosure is specifically required or permitted by law.

SPECIFY Check the box and initial to specify which type of information is to be disclosed.

RECORDS:

☐ **MEDICAL INFORMATION** _____ INITIAL

☐ **PSYCHIATRIC INFORMATION**
_____ SIGNATURE _____ DATE

☐ **DRUG/ALCOHOL INFORMATION** _____ DATE

☐ **RESULTS OF AN HIV BLOOK TEST**
_____ SIGNATURE _____ DATE

☐ **OTHER HEALTH INFORMATION** _____ (specify below)

Specify the records to be disclosed: _____

The requester may use the health information authorized on this form for the following purposes only: _____

Date: Signature: