Kaiser Foundation Health Plan, Inc.
Kaiser Foundation Hospitals
The Permanente Medical Group, Inc.

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:

Name of Disclosing Party

Address

City State ZIP

To disclose to:

Name of Recipient

Address

City State ZIP

If requesting your own records for yourself, specify facilities: _____

Records and information pertaining to:

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

Address | Telephone Number

DURATION: