KAISER PERMANENTE® HAWAII REGION
3288 Moanalua Road, Honolulu, HI 96819
Phone: (808) 432-5092 Fax: (808) 432-5070

# Authorization for Release of Protected Health Information

**Note: Fees may apply to certain requests**

*Patient Name: ___________________________________

MRN: ____________________*DOB: ________________

SSN (last 4 digits only): _________

*I hereby authorize: ☐ Kaiser Permanente ☐ Other Facility/Provider: ________________________________________

*To: ☐ Kaiser Permanente Attention: ___________________________________________________________
(KP Provider or Clinic Department)

☐ Patient ☐ Physician, Other Person or Institution: ______________________________________________

Address: ______________________________________________________________________________

City: ____________________________________ State:_________________________ Zip Code:________________

*To disclose/obtain the following information on the above named patient:
Unless otherwise indicated, medical records will be sent by electronic media.

☐ Send medical records copies on paper.
☐ CD ☐ Flash Drive ☐ Email address:___________________________________________

*Description of information/records requesting:

☐ Both Hospital and Clinic Records ☐ Clinic Records ☐ Hospital Records
☐ Records of Specific Provider: _____________________________________ or Dept.______________________________
☐ X-Ray Films/Images ☐ X-Ray Report/Results ☐ Lab Results ☐ Immunizations
☐ Other (please specify: ______________________________________________________________________

*For the purpose of:

☐ At the Request of the Individual ☐ Legal Purposes ☐ Insurance ☐ School
☐ Continuing Care/Treatment ☐ Other: ___________________________________________________________

________ (initials) **I agree to the disclosure of the following information should it be contained in my record: HIV, AIDS, AIDS Related Complex; alcohol/drug dependency treatment records; mental health records.**

***DURATION: This authorization shall remain in effect for one year from date of signature unless a different date is specified here ____________________ (date).**

**REVOCATION: I can revoke this authorization by submitting a letter to Health Information Management at 501 Alakawa Street 2nd floor, Honolulu, HI 96817. A revocation will not affect information disclosed prior to receipt of the revocation.**

**REDISCLOSURE: Information released under this authorization may be re-released by the recipient and no longer protected under federal privacy rules.**

**I understand that Kaiser Permanente may not condition my treatment, payment, enrollment or eligibility for benefits on providing or refusing to provide this authorization, except for (i) research related treatment, (ii) health care provided solely for disclosure to a third party, or (iii) health plan initial enrollment/eligibility determinations, risk rating or underwriting.**
**I understand I have a right to receive a copy of this authorization.**

***Date: ______________ *Signature: __________________________________ *Print Name: _____________________________**

**If signed by someone other than the patient or parent of a minor child, please indicate relationship. Submit documents to show authority to request information on the patient.**

***Relationship to Patient: _________________________________ Phone Number: (______)______________________**

*Items that MUST be completed for authorization to be valid