



**KAISER  
PERMANENTE**

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

Authorized Agent:  
Knox Attorney Service, Inc./ Knox Services LLC.

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

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).

**REVOCATION:** 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-** I understand that the recipient may not lawfully further use or disclose the health

**CLOSURE:** 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**

\_\_\_\_\_ (Initial)

**PSYCHIATRIC INFORMATION**

\_\_\_\_\_ Signature

\_\_\_\_\_ Date

**DRUG/ALCOHOL INFORMATION**

\_\_\_\_\_ Signature

\_\_\_\_\_ Date

**RESULTS OF AN HIV TEST**

\_\_\_\_\_ Signature

\_\_\_\_\_ Date

**GENETIC RECORDS**

\_\_\_\_\_ Signature

\_\_\_\_\_ Date

**OTHER HEALTH INFORMATION**

\_\_\_\_\_ (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.

Authorized Agent:  
Knox Attorney Service, Inc.  
Knox Services LLC.

Date

Signature

If Signed by Other than Member/Patient, Indicate Relationship