



(\*Kaiser Permanente entities are listed on reverse side of this form)

**AUTHORIZATION FOR USE OR DISCLOSURE OF PATIENT HEALTH INFORMATION**

Note: Fees may apply to certain requests

Patient Name: \_\_\_\_\_  
Medical Record number: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_  
Zip Code: \_\_\_\_\_ Phone #: ( ) \_\_\_\_\_  
Email: \_\_\_\_\_

Kaiser Permanente may release this information to:  Check if same as above

Recipient Name: Hoosier Services Inc  
Address: 18032 Lemon Dr Ste C-618 City: Yorba Linda State: CA Zip Code: 92886  
Phone # ( 800 ) 882.4156 /Fx: 800.882.4957 Email: service@hoosierservicesinc.com

This disclosure can be used for the following purpose(s):  Personal Use  Legal  Insurance  
 Medical Treatment  Medical Condition Verification  Disability  FMLA  Workers' Comp

Check ONLY one of the following three options to identify the health information to be released.

- Option 1: Form Completion (a substitute form or relevant medical records may be released)
- Option 2: Last 2 years of Kaiser Permanente Medical Office and Kaiser Foundation Hospital records
- Option 3: Records as specified. You must complete Step 1 and Step 2 below.

Step 1. Enter date range or date(s) of the records to be released: X \_\_\_\_\_

Step 2. Select types of records to be released:

- KP Medical Office  Kaiser Foundation Hospital  Immunization  Lab Results
- Diagnostic Images  Copays & Deductibles  Itemized Billing  Pharmacy
- Other (provider, department, specialty): \_\_\_\_\_

**NOTE:** Hospital and Medical Office records released as part of this authorization may contain references related to mental health, addiction, and HIV medical conditions.

Check the boxes below if you want this release to include the following information, Otherwise, this information will be excluded.

Mental Health Treatment Records  Addiction Medicine Treatment Records  HIV Test Results

Media Type:  Electronic  Paper Delivery Preference:  Electronic  Mail  Pickup

**DURATION:** Authorization shall remain in effect for one year from the date of signature below. However, in Washington, D.C. permission to release addiction medicine treatment records expires after six (6) months.

**REVOCATION:** You or your personal representative may cancel this authorization for future releases by submitting a written request to the Release of Information Unit listed for your region of service on the reverse side of this form. Your cancellation will not affect information that was released prior to receipt of the written request.

**REDISCLASURE:** Once this information is released, it may not be protected under federal privacy law (HIPAA). State or other federal law may require the recipient to obtain your authorization before further disclosure.

Kaiser Permanente may not condition treatment, payment, enrollment, or eligibility for benefits on whether you sign this authorization. This disclosure is made at your request. For Virginia patients, a copy of this authorization, and a note stating to whom your information was disclosed will be included in your medical record. A copy of the original authorization is valid. You have a right to a copy of this completed authorization.

X \_\_\_\_\_  
Date Signature

\_\_\_\_\_  
If personal representative, print name/relationship