KAISER PERMANENTE®

Patient Name: _____

Medical Record Number: _____

Birth Date: _____ Email: _____

Do not use for patient copies of or access to their medical records. Patients should go to kp.org/requestrecords to conveniently request medical records, FMLA and Disability certifications.

AUTHORIZATION FOR USE OR DISCLOSURE OF PATIENT HEALTH INFORMATION
To the Following Third-Party Recipient (Fees may be required)

Recipient Name: NW Regional Education Service District

Address: 5825 NE Ray Circle

City: Hillsboro State: OR Zip Code: 97124

Phone # (503) 614-1633 Email: ris@nwresd.k12.or.us

This disclosure can be used for the following purpose(s): ❑ Legal ❑ Insurance ❑ Medical Certification ❑ Other

Hospital and Medical Office records released as part of this authorization may contain references related to mental health, addiction, and HIV medical conditions documented by primary care.

I authorize the following to be disclosed for the selected time frame:

☒ Form Completion (a substitute form or relevant medical records may be released in lieu) ☒ Medical Records

❑ Diagnostic Images ❑ Itemized Billing Records ❑ Pharmacy Copays ❑ Medical Copays

Time Frame: Last ❑ 2 months ❑ 6 months ❑ 1 year ☒ 2 years ❑ 5 years ❑ All electronic records

Check the boxes below if you want this release to include the protected treating department or HIV initial test result information. If not checked, this treating department information will be excluded.

❑ Mental Health Treatment Records ❑ Addiction Medicine Treatment Records ❑ HIV Lab Test Results

Kaiser Permanente Oregon locations need to **also** check this box if they want Genetic Testing information released. ☒

DURATION: Authorization shall remain in effect for 6 months from the date of signature below.

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 found on kp.org/requestrecords. Your cancellation will not affect information that was released prior to receipt of the written request.

REDISCLOSURE: 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.

We will provide the requested information in electronic format to the recipient unless the recipient contact us to make other arrangements.

Date _____ Signature _____ If personal representative, print name/relationship _____

Instructions:

1) Complete the patient identification information on the top right-hand corner
2) Complete all required information for the recipient including a valid email address
3) Check the box for purpose of disclosure
4) Check the box(es) for the type of information to be disclosed and also check the box for a timeframe
5) If you want specially protected information to be included, check the appropriate box(es)
6) Enter the date you are signing the authorization
7) Sign the form
8) If you are a personal representative, print your name and relationship. We may reach out for you to provide additional documentation if needed.
9) Submit this form to the third party you are authorizing to obtain records
10) Keep a copy for your records

"Kaiser Permanente" means both your insurance company (a Kaiser Permanente health plan) and your doctors (a Permanente medical or dental group). It also includes different groups depending on where you live.

To find contact information go to kp.org and search locations for your region/market listed below or alternatively go to kp.org/requestrecords and indicate your region/market.

All states where we do business:
- Kaiser Foundation Hospitals
- Kaiser Permanente Insurance Company

Colorado:
- Kaiser Foundation Health Plan of Colorado
- Colorado Permanente Medical Group, P.C.

Georgia:
- Kaiser Foundation Health Plan of Georgia, Inc.
- The Southeast Permanente Medical Group, Inc.

Mid-Atlantic (Maryland/Virginia/Washington, D.C.):
- Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
- Mid-Atlantic Permanente Medical Group, P.C.

Washington:
- Kaiser Foundation Health Plan of Washington
- Washington Permanente Medical Group, P.C.

California - North:
- Kaiser Foundation Health Plan, Inc., Northern California Region
- The Permanente Medical Group, Inc.

California - South:
- Kaiser Foundation Health Plan, Inc., Southern California Region
- Southern California Permanente Medical Group

Hawaii:
- Kaiser Foundation Health Plan, Inc., Hawaii Region
- Hawaii Permanente Medical Group, Inc.
- Maui Health Systems

Northwest (Oregon/SW Washington):
- Kaiser Foundation Health Plan of the Northwest
- Northwest Permanente, P.C.
- Permanente Dental Associates, P.C.

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To the Following Third-Party Recipient (Fees may be required)

Recipient Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone # (_____) _____ Email: _____

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