KAISER PERIMIANENTE, Southern California

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

AUTHORIZATION FOR USE AND DISCLOSURE OF PHARMACY INFORMATION (SOUTHERN CALIFORNIA)

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 authodze:
Kaiser Permanente Pharmacy,
Kaiser Foundation Health Plan Pharmacy,
and / or Kaiser Foundation Hospital Pharmacy

Disclose to:

_____
Print Name of Recipient

_____
Address

_____
City State Zip

Records and information pertaining to:

_____ _____ _____
Print Name of Recipient Medical Record Number Date of Birth

_____ _____
Address City Zip Telephone Number

DURATION: This authorization shall become effective immediately and shall remain in effect for this single request for records; after which the authorization shall expire. A new authorization form will be required for each future request.

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.

REDISCLOSURE: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

SPECIFY RECORDS: ☐ **Dispensing summary (e.g., tax records).**

Request for the period from _____ to _____
MNVDDW MMODW

Records up to the past 36 months are available as a courtesy. Records beyond 37 months are assessed a service fee of $15.00 per request / per member / patient. Enclose check or money order made to the order of: Kaiser Foundation Hospitals (KFH). DO NOT SEND CASH.

The recipient may use the pharmacy 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. Please send a copy of Power of Attorney, Death Certificate, or other legal document as it applies to request of records for another member / patient.

_____ _____ _____
Date Signature If Signed by Other than Member/Patient, Indicate Relationship

Make a copy for your records and **Mail** completed form to: ➔

Kaiser Permanente
Pharmacy Informatics
PO Box 5075
Livermore, CA 94551-5075

Faxed copies will not be accepted.