KAISER PERMANENTE®

AUTHORIZATION TO DISCLOSE PROTECTED and PRIVILEGED HEALTH INFORMATION

→ State of Georgia Employee Group Use Only ←

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

I hereby authorize:
Kaiser Permanente – HIMS Release of Information Dept.

4000 Dekalb Technology Parkway, Suite 200

Atlanta, GA 30340

To disclose to:

Name of Recipient

Address

City, State Zip

Pick up is available at select locations by appointment:

Monday – Friday 9am – 5pm
- Dekalb Tech HIMS (address above)

Tuesday – Friday 1 pm – 5pm
- Crescent Centre, 200 Crescent Centre Parkway, Tucker, GA 30084
- Southwood, 2400 Mt. Zion Parkway, Jonesboro, GA 30236

Saturday 9 am – 1 pm
- Dekalb Tech HIMS
- Southwood

Distribution:
- ❑ Mail to Address Above
- ❑ Fax Number _____
- ❑ Pick up at:
  - ❑ Dekalb Tech
  - ❑ Southwood
  - ❑ Crescent Centre

You will be contacted when your information is ready to confirm pick-up location and time.

I am requesting:
- ❑ My own records
- ❑ My child's records (under 18 years old)
- ❑ * Child / Adult records - I am legal guardian

**(Copy of legal documents must accompany request)*

Records and information pertaining to:

Name of Member/Patient (List other names used)_____ Medical Record Number

Date of Birth_____ Phone Number_____

Address_____

❑ Most current 3 years of clinical information on:

❑Jump Drive $ 25.00 ❑ Paper $ 45.00
❑ CD $ 21.00 ❑ Fax to New MD $ 0

❑ More than 3 years of clinical information on:

❑Jump Drive $ 53.00 ❑ Paper $ 87.00
❑ CD $ 45.00 ❑ Fax/Mail to New MD $0

❑ Radiology images (exam/date) _____ ❑ DVD $2.00 per image ❑ Film $5.00 per image

Records subject to disclosure: I understand that **all** clinical records, including but not limited to, medical information, psychiatric information, drug / alcohol information, and HIV information including test results will be provided under this authorization to disclose health information ***unless specifically limited and initialed below:***

Do not release: ❑ Psychiatric ❑ Drug/Alcohol ❑ HIV **Please Initial Here** _____

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 _____.

Revocation: This authorization is also subject to written revocation by the member/patient at any time. The written revocation will be effective upon receipt by the HIMS Department, 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 discloser is specifically required or permitted by law.

Payment: Pursuant to O.C.G.A. §31-33-3 payment for all requested information is due prior to release/disclosure.

Recipient Use: The recipient may use the health information authorized on this form for the following purposes:

❑ Personal Copy ❑ Continuity of Care

A copy of this authorization is valid as the original. Member/patient has a right to a copy of this authorization.

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

NOTE TO RECEIVING PERSON/PARTY: Information disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected by 45 CFR Subtitle A, Subchapter C, Section 164.508. If this release pertains to alcohol or drug information, please note that this information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulation (42 CFR part 2) prohibits you from making further disclosure of it without the specific written consent of the patient to whom it pertains as otherwise permitted such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.