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**I am not a robot!**

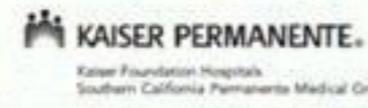
## Kaiser permanente release of information form oregon

Kaiser Permanente health plans around the country: Kaiser Foundation Health Plan, Inc., in Northern and Southern California and Hawaii • Kaiser Foundation Health Plan of Colorado • Kaiser Foundation Health Plan of Georgia, Inc., Nine Piedmont Center, 3495 Piedmont Road NE, Atlanta, GA 30305, 404-364-7000 • Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., in Maryland, Virginia, and Washington, D.C., 2101 E. Jefferson St., Rockville, MD 20852 • Kaiser Foundation Health Plan of the Northwest, 500 NE Multnomah St., Suite 100, Portland, OR 97232 • Kaiser Foundation Health Plan of Washington or Kaiser Foundation Health Plan of Washington Options, Inc., 1300 SW 27th St., Renton, WA 98057 Loading, just a moment... A basic summary of your online health record. [guru](#) It meets most needs, including changing your physician or switching to another health plan. Learn more. Visit my medical records to view and print your or your family members' most commonly requested medical records and reports from Kaiser Permanente Northwest, including the following: You can specify the date range, which medical records, and the party receiving the copy of your medical records. Allow 5 business days for the completion of your request. Note that Hospital and Medical Office records released as part of this request may contain references related to mental health, addiction, and HIV conditions. Order an electronic copy of your detailed medical records. Current and former KP members can access most of their medical records from Kaiser Permanente Northwest at any time from kp.org. Access your record by doing the following: Log in to kp.org and choose Medical Record from the menu at the top. Select from options on the menu on the left side of the screen and follow the onscreen prompts to view and/or download the most commonly requested medical records, including immunizations, test results, visit summaries, and hospital records. Records not available on kp.org can be sent to you upon request. Send an email to [nw.roi@kp.org](mailto:nw.roi@kp.org) identifying yourself with name, birthdate, health record number, and phone number. Supply a date range for the records you need, and they will be sent to your email address on file in a secure password-encrypted PDF format. You will be able to open the file on any computer or smart phone and have the ability to search it, print it, or forward it. If you aren't certain if your email address on file is correct, please contact Membership Services to update your records. If you want your medical records sent to a third party, including a family member, your signature is required. Complete and sign in ink the Authorization for Kaiser Permanente to Use/Disclose Protected Health Information (PDF). Send the completed, signed form, and payment (if required, see below) via email, or postal mail to: Email: [nw.roi@kp.org](mailto:nw.roi@kp.org) Mail: Kaiser Permanente Release of Information Department 10220 SE Sunnyside Road, Clackamas, OR 97015 Cost of records Electronic records are provided free of charge to patients, whether current or former members. If printed records are required, up to 25 pages are provided free of charge. Additional pages are subject to a per-page printing fee and shipping costs via secure carrier. Please contact us via email at [nw.roi@kp.org](mailto:nw.roi@kp.org) or phone at 503-571-5051 for cost information. Third parties requesting records are charged \$16.50, representing the average cost of producing records, plus sales tax, if applicable. Third parties should supply an email address to receive password-encrypted medical records.



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Kaiser Foundation Hospitals  
Southern California Permanente Medical Group

**AUTHORIZATION FOR RELEASE AND / OR  
DISCLOSURE OF MEDICAL INFORMATION**

Treatment, payment, enrollment or eligibility for benefits will not be conditioned on my providing or refusing to provide this authorization.

Please REQUEST Medical Information FROM:

IMPRINT KAISER PERMANENTE © CARD HERE

Please SEND Medical Information TO:  G RONSON  
PHOTOCOPY INC

Name of Health Care Provider

Name of Person or Entity to Receive Information

Name of Medical Office/Hospital

Title (Physician, Therapist, Attorney)

Street Address

Street Address

City, State and Zip Code

City, State and Zip Code

I hereby authorize  to release and / or disclose the medical information as indicated below to the health care provider, entity, or person I have indicated above.

Release and / or disclose records and information regarding:

Name of Patient (List Other Names/Medical Record Number/Date of Birth)

Address/City/State/Zip Code/Telephone Number

**DURATION:** This authorization shall become effective immediately and shall remain in effect until  (enter date) or for one year from the date of signature if no date entered.

**REVOCATION:** This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosing party. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received.

**REDIS-CLOSURE:** I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless disclosure is specifically required or permitted by law.

**SPECIFY RECORDS TO BE RELEASED AND / OR DISCLOSED:** Check the box and initial which type of information is to be released and / or disclosed:

General Medical Information (from  to )  Information Regarding Specific Injury or Treatment (from  to )

X-Ray (check one or both):  Films  Reports

Laboratory Results  Mental Health (from  to )

Alcohol / Drug (from  to )  Signature of Patient or Patient's Representative

HIV Test Results (from  to )  Signature of Patient or Patient's Representative

Other (specify):  Signature of Patient or Patient's Representative

I request that the health information released and / or disclosed pursuant to this authorization be used for the following purposes only:

A copy of this authorization is valid as an original.

I have the right to receive a copy of this authorization. The copy is for me to keep.

Date/Signature of Patient or Patient's Representative

Indicate Relationship (if Signed by Other than Patient)

NS-06N (10/05) HIPAA COMPLIANCE

DISCLOSING PARTY

CHART

PATIENT

It meets most needs, including changing your physician or switching to another health plan. Some Learn more. Visit my medical records to view and print your or your family members' most commonly requested medical records and reports from Kaiser Permanente Northwest, including the following: You can specify the date range, which medical records, and the party receiving the copy of your medical records. Allow 5 business days for the completion of your request.

Note that Hospital and Medical Office records released as part of this request may contain references related to mental health, addiction, and HIV conditions. Order an electronic copy of your detailed medical records. [gelexalo](#) Current and former KP members can access most of their medical records from Kaiser Permanente Northwest at any time from kp.org.

Access your record by doing the following: Log in to kp.org and choose Medical Record from the menu at the top. Select from options on the menu on the left side of the screen and follow the onscreen prompts to view and/or download the most commonly requested medical records, including immunizations, test results, visit summaries, and hospital records. Records not available on kp.org can be sent to you upon request. [nayimotocumuwu](#) Send an email to nw.roi@kp.org identifying yourself with name, birthdate, health record number, and phone number. Supply a date range for the records you need, and they will be sent to your email address on file in a secure password-encrypted PDF format.

If you aren't certain if your email address on file is correct, please contact Membership Services to update your records. If you want your medical records sent to a third party, including a family member, your signature is required. Complete and sign in ink the Authorization for Kaiser Permanente to Use/Disclose Protected Health Information (PDF). Send the completed, signed form, and payment (if required, see below) via email, or postal mail to: Email: nw.roi@kp.org Mail: Kaiser Permanente Release of Information Department 10220 SE Sunnyside Road, Clackamas, OR 97015 Cost of records Electronic records are provided free of charge to patients, whether current or former members. If printed records are required, up to 25 pages are provided free of charge. Additional pages are subject to a per-page printing fee and shipping costs via secure carrier. Please contact us via email at nw.roi@kp.org or phone at 503-571-5051 for cost information. Third parties requesting records are charged \$16.50, representing the average cost of producing records, plus sales tax, if applicable. Third parties should supply an email address to receive password-encrypted medical records. There may be additional charges for radiology images. There is no charge for transferring information to non-Kaiser clinicians for ongoing medical care.

You must provide details about the frequency of flare-ups, e.g., number of episodes per month and duration of episodes. [ravirutohuyuxu](#) A reduced work schedule also falls under intermittent leave. [cerezira](#) Parental leave for baby bonding: Parental leave is an entitlement and does not require medical certification nor is your clinician's signature required. You only need to provide proof of birth, such as a birth certificate, hospital discharge paperwork, or after-visit summaries. Modification of an existing leave: If any of the above requests require modification after they have already been approved, please contact your clinical team to have your work status updated. Short-term and long-term disability coverage protect employees when they are off the job for a period of time due to illness or injury. These benefits are typically provided through an insurance carrier designated by your employer, who will supply you with a form. Kaiser will substitute a universal attending physician statement that your disability carrier will accept. Complete the following: Submit the form provided to you by your disability carrier. [dakugoko](#)

INCLUDE a completed Intake form (PDF) to initiate your STD/LTD request. INCLUDE a signed authorization form to permit the transmission of your completed form(s) to your insurance carrier.

Kaiser Permanente		Kaiser Foundation Hospitals Southern California Permanente Medical Group	
AUTHORIZATION TO DISCLOSE HEALTH INFORMATION TO KAISER PERMANENTE			
I hereby authorize: <input type="checkbox"/> to disclose to: <input type="text"/> Kaiser Permanente at <input type="text"/> Location			
Provider's Name	None of Provider	Street Address	City, State and Zip
Records and information pertaining to:			
First Name	Date of Birth	Daytime Phone	Medical Record Number
Street Address			
The type and amount of information to be disclosed is as follows (specify dates where appropriate):			
<input type="checkbox"/> Most recent 2 years of record for adult patients <input type="checkbox"/> Pediatric Patients <input type="checkbox"/> Immunization Record <input type="checkbox"/> Radiology Reports, from date <input type="text"/> to <input type="text"/> <input type="checkbox"/> Radiology Images (exams): <input type="checkbox"/> All Radiology Images (exams and imaging Reports) <input type="checkbox"/> Laboratory Results, from date <input type="text"/> to <input type="text"/> <input type="checkbox"/> Other records not listed (specify): <input type="text"/>			
1. I understand that the medical information released may include any and all information concerning treatment, diagnosis, mental illness, alcohol/drug abuse, and HIV/AIDS information.			
2. I understand that although disclosure of health information for treatment purposes from provider to provider is generally considered a professional courtesy, a health care provider may only release information to a Kaiser Permanente provider if the information has already become part of the patient's Kaiser Permanente medical record.			
3. I understand that a Kaiser Permanente provider may review the records to determine what information may be released to a Kaiser Permanente provider if the information has already become part of the patient's Kaiser Permanente medical record.			
PURPOSE: The health information disclosed is to be used for community care purposes.			
DURATION: This authorization shall remain in effect for one year from the date of signature unless a different date is specified here (date): <input type="text"/>			
REVOCATION: You or your representative can revoke this authorization upon written request. If you revoke, it will not affect information already released or the receipt of the written request.			
DISCLOSURE: Once this information is disclosed, there is no right to further disclosure. It may not be protected under federal privacy law (HIPAA). Certain records are required to obtain your authorization before further disclosing this information.			
A copy of this authorization is valid as the original. I have a right to a copy of this authorization.			
Signature of Patient or Patient's Representative		Name	
Personal Representative's Name Print and Signature		Relationship	

Note that Hospital and Medical Office records released as part of this request may contain references related to mental health, addiction, and HIV conditions. Order an electronic copy of your detailed medical records. Current and former KP members can access most of their medical records from Kaiser Permanente Northwest at any time from kp.org. [guleru](#) Access your record by doing the following: Log in to kp.org and choose Medical Record from the menu at the top. Select from options on the menu on the left side of the screen and follow the onscreen prompts to view and/or download the most commonly requested medical records, including immunizations, test results, visit summaries, and hospital records. Records not available on kp.org can be sent to you upon request. Send an email to nw.roi@kp.org identifying yourself with name, birthdate, health record number, and phone number. Supply a date range for the records you need, and they will be sent to your email address on file in a secure password-encrypted PDF format. You will be able to open the file on any computer or smart phone and have the ability to search it, print it, or forward it. [jepero](#) If you aren't certain if your email address on file is correct, please contact Membership Services to update your records. If you want your medical records sent to a third party, including a family member, your signature is required. Complete and sign in ink the Authorization for Kaiser Permanente to Use/Disclose Protected Health Information (PDF). Send the completed, signed form, and payment (if required, see below) via email, or postal mail to: Email: nw.roi@kp.org Mail: Kaiser Permanente Release of Information Department 10220 SE Sunnyside Road, Clackamas, OR 97015 Cost of records Electronic records are provided free of charge to patients, whether current or former members. If printed records are required, up to 25 pages are provided free of charge. Additional pages are subject to a per-page printing fee and shipping costs via secure carrier. Please contact us via email at nw.roi@kp.org or phone at 503-571-5051 for cost information. Third parties requesting records are charged \$16.50, representing the average cost of producing records, plus sales tax, if applicable. Third parties should supply an email address to receive password-encrypted medical records. There may be additional charges for radiology images. There is no charge for transferring information to non-Kaiser clinicians for ongoing medical care.

Please complete the steps above and include the clinician's complete mailing address, and phone number. Still have questions? If you have additional questions, click here to contact the Release of Information department for additional assistance. Work leave and accommodations If medically appropriate, a medical certification form can be submitted to an employer or leave administrator to determine your eligibility for: Family and Medical Leave Act (FMLA) Oregon Family Leave Act (OFLA) Paid Leave Oregon (PLO) Washington Paid Family and Medical Leave (PFML) FMLA and OFLA protect your absence from work due to a serious health condition to care for yourself or an eligible family member. PLO and PFML provide financial benefits in addition to work leave protection. All four programs except the federal FMLA medical certification form Kaiser will provide. No other forms are required. Refer to your employer or leave administrator for details on your organization's policies on timing for requesting leave and how to submit your form. Click the link below to request medical certification. Do not submit forms for medical certification (FMLA, OFLA, PLO, or PFML) directly to your clinician. Requests submitted through the link below will be routed to your clinician for review.

KAISER PERMANENTE			
Patient Name: <input type="text"/> Medical Record Number: <input type="text"/> Birth Date: <input type="text"/> Email: <input type="text"/>			
Do not use for patient copies of or access to their medical records. Patients should go to <a href="#">kp.org/requestrecords</a> 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)			
<input type="text"/> Recipient Name: <input type="text"/> Address: <input type="text"/> City: <input type="text"/> State: <input type="text"/> Zip Code: <input type="text"/> Phone #: <input type="text"/> Email: <input type="text"/>			
This disclosure can be used for the following purpose(s): <input type="checkbox"/> Legal <input type="checkbox"/> Insurance <input type="checkbox"/> Medical Certification <input type="checkbox"/> 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.			
<input type="checkbox"/> I authorize the following to be disclosed for the selected time frame: <input type="checkbox"/> Form Completion (a substitute form or relevant medical records may be released in lieu) <input type="checkbox"/> Medical Records <input type="checkbox"/> Diagnostic Images <input type="checkbox"/> Remitted Billing Records <input type="checkbox"/> Pharmacy Copies <input type="checkbox"/> Medical Copies Time Frame: Last <input type="checkbox"/> 2 months <input type="checkbox"/> 6 months <input type="checkbox"/> 1 year <input type="checkbox"/> 2 years <input type="checkbox"/> 5 years <input type="checkbox"/> 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.			
<input type="checkbox"/> Mental Health Treatment Records <input type="checkbox"/> Addiction Medicine Treatment Records <input type="checkbox"/> HIV Lab Test Results Kaiser Permanente Oregon locations need to also check this box if they want Genetic Testing information released. <input type="checkbox"/>			
DURATION: Authorization shall remain in effect for 6 months from the date of signature below.			
REVOCATION: You or your personal representative can 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 <a href="#">kp.org/requestrecords</a> . 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: <input type="text"/>		Signature: <input type="text"/>	
If personal representative, print name/relationship: <input type="text"/>			

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