Kaiser Permanente
Southern California Permanente Medical Group
Kaiser Foundation Hospitals

AUTHORIZATION FOR RELEASE OF MEDICAL DATA

Release To: _____

Address: _____

Reason for Release: _____

Information on:
Patient's name _____ Medical Record # _____ Birth Date _____

Work Phone # ( ) _____

☐ I hereby authorize KAISER FOUNDATION HOSPITALS and/or the SOUTHERN CALIFORNIA PERMANENTE MEDICAL GROUP to furnish the above named individual or company all medical data they may request (including X-ray and laboratory reports) concerning my illness or injury. Information about diagnosis and treatment of AIDS as well as test results for the virus that causes AIDS, HIV, will be released if part of the medical report.

☐ I hereby authorize KAISER FOUNDATION HOSPITALS and/or the SOUTHERN CALIFORNIA PERMANENTE MEDICAL GROUP to furnish the above named individual or company all the medical data regarding diagnosis, care and treatment for alcohol abuse or drug abuse or mental health from _____ to _____.

Indicate limitations, if any, of medical information to be released and/or restrictions, if any, or how such information is to be used:

_____
_____
_____

This consent is subject to revocation by the undersigned at any time except to the extent that action has been taken in reliance hereon, and if not earlier revoked it shall terminate six months from date of consent without express revocation.

The patient may receive a copy of this authorization if requested.

_____ _____
Date Patient Signature

_____
Parent or Legal Guardian

_____
Relationship