KAISER PERMANENTE®

AUTHORIZATION TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION

1. I authorize Kaiser Foundation Health Plan of Ohio and/or The Ohio Permanente Medical Group, Inc. to disclose and or receive for use the following information for the individual named below:

Patient Name: ______________________ Kaiser Medical Record #: ____________________

Address: ____

City/State/Zip: ____

Phone #: ( ) ______________________ Date of Birth ____________________

2a. **I AUTHORIZE:**

____
Name of sending person/organization
Examination Mgt Svcs Inc
654 Portage Trail Ste 4
____
St**Cuyahoga Falls OH 44221**
330-923-8255

____
City State Zip Code

2b. **TO RELEASE TO:**

Kaiser Permanente
Medical Correspondence
5410 Lancaster Drive
Brooklyn Heights, OH 44131

3. At my request the following information may be disclosed and or used : *(specify dates where appropriate)*

Immunizations	*Date(s):* ______	Laboratory Results	*Date(s):* ______
Medical Record	*Date(s):* ______	HIV/AIDS Test Results	*Date(s):* ______
Medical Record (last two years)		Mental Health Record	*Date(s):* ______
X-Ray Reports	*Date(s):* ______	Billing Record	*Date(s):* ______
X-Ray Films	*Date(s):* ______	Other Records	*Date(s):* ______
(specify type) ______		*(specify type)* ______	

For the purpose of: *(check all that apply)*

Continuity of Care	Personal Use	Consultation	Insurance Claim
Form Completion	Attorney Inquiry	Social Security	Workers' Comp
Eligibility/Enrollment	Rate Setting	Employer Request	Appeals

Other (Specify) ______________________

Signature and date must be on Page 2 for this authorization to be valid.

Revised 5/16/03; 1/01/04