AUTHORIZATION FOR USE AND DISCLOSURE OF PHARMACY INFORMATION

Instructions

Patient self-request for prescription dispensing records

- Complete Authorization for Use and Disclosure of Pharmacy Information on Page 2
- Patient must date and sign the authorization form

If the request is from an individual other than patient

- Individual must date, sign, and indicate relationship to the patients on the authorization form
- Individual must also include evidence of the legal authority to act on behalf of the patient along with the form. Evidence includes, but not limited to:
    - Letters of Guardianship
    - Letters of Conservatorship
    - Power of Attorney
    - Death Certificate

Submit completed form and fee, if applicable, by mail (fax copies not accepted) to:
Kaiser Permanente
Pharmacy Informatics
PO Box 5075
Livermore, CA 94551-5075

Third Party Requests (i.e. law firms, housing developments, etc)

- Complete Authorization for Use and Disclosure of Pharmacy Information on Page 2
- Patient must date and sign the authorization form
- Third Party must also include evidence of legal authority to act on behalf of the patient along with the form. Evidence includes, but limited to:
    - Notice that individual has retained Third Party's services on the company letter head

Third party requests may be sent to:
Kaiser Permanente
Pharmacy Records Request Desk
12254 Bellflower Blvd
Downey, CA 90242

Subpoenas and court orders must be served in person to the Pharmacy Custodian of Records at the address listed above.

Fees:

- NCAL: Request for records up to the past 30 months is available as a courtesy. Records beyond 30 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.
- SCAL: Request for records up to the past 36 months is available as a courtesy. Records beyond 36 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.

KAISER PERMANENTE®

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Kaiser Permanente will not condition treatment, payment, enrollment or eligibility for benefits on providing, or refusing to provide this authorization

Patient Information:

Member's Region
☐ Northern California
☐ Southern California

Print Name of Patient _____ Medical Record Number _____

Address _____ Date of Birth _____

City _____ State _____ Zip _____ Email _____ Telephone Number _____

I hereby authorize: Kaiser Permanente Pharmacy, and / or Kaiser Foundation Health Plan Pharmacy, and / or Kaiser Foundation Hospital Pharmacy to disclose to:

Print Name of Recipient _____

Address _____

City _____ State _____ Zip _____

SPECIFY THE PHARMACY INFORMATION TO BE USED OR DISCLOSED (mark all that apply):

☐ Pharmacy Records dated from _____ to _____
☐ Specific Drugs(s)/Medication(s) Records: _____ dated from _____ to _____
☐ Medical Expenses Detail Summary dated from _____ to _____
☐ Other (specify): _____

NOTE: Pharmacy records including any information related to alcohol/drug treatment will not be disclosed unless specifically authorized below. SIGNATURE AND DATE IS REQUIRED IF BOX IS CHECKED.

☐ Alcohol / Drug dated from _____ to _____ Signature: _____ Date: _____

Media Type: ☐ Electronic (Preferred) ☐ Paper

Delivery Preference: ☐ Email (Preferred) _____ ☐ Mail

PURPOSE: The pharmacy records and information disclosed may only be used for the following purpose(s): _____.

DURATION: This authorization shall remain in effect for one year from the date of my signature below unless a different date is specified here _____ (date).

REVOCATION: You or your personal representative can revoke this authorization upon written request. If you revoke, it will not affect information disclosed before the receipt of your written request to revoke.

REDISCLOSURE: I understand that information disclosed pursuant to this authorization may no longer be protected under federal privacy law (HIPAA) and could be re-disclosed by the recipient. However, California law may prohibit the recipient's re-disclosure of my information.

A copy of this authorization is as valid as the original. I have the right to receive a copy of this authorization.

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

VERIFICATION OF SIGNEE'S IDENTITY (For Internal Use Only) Date:

The identity of the Member / Patient or Personal Representative was verified using the attached:
☐ Driver's License ☐ Other Photo Identification ☐ Notarized Document ☐ Other

The legal authority of Personal Representative (if applicable) was verified using the attached:
☐ Letters of Guardianship ☐ Letters of Conservatorship ☐ Power of Attorney ☐ Other