Kaiser Foundation Health Plan, Inc. Kaiser Foundation Hospitals The Permanente Medical Group, Inc.

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF MEMBER/PATIENT **HEALTH INFORMATION**

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

I hereby authorize: Name of Disclosing Party			To disclose to: Name of Recipient		
City	State	ZIP	City	State	ZIP
If requesting y	our own records fo	r yourself,	specify facilities:		
Records and in	nformation pertaini	ng to:			
Name of Member/Patient (List Other Names Used)			Medical Record Number	Date of Birth	
Address				Telephone Number	
DURATION:					