



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

**OH&SS**  
**For Disclosing Kaiser**  
**Permanente Records to**  
**Employer**

MR #: \_\_\_\_\_

Name: \_\_\_\_\_

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

IMPRINT AREA

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: Kaiser Permanente**  
**Occupational Health Northern California**

**to disclose to:**

Name of Disclosing Party

Name of Recipient

Address

Address

City State ZIP

City State ZIP

**records and information pertaining to:**

Name of Member/Patient (List Other Names Used)

Medical Record Number

Date of Birth

Address

Telephone Number

**DURATION:** This authorization shall become effective immediately and shall remain in effect for the duration of my employment with the above referenced employer plus 30 years.

**REVOCACTION:** This authorization is also subject to written revocation by the member/patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization.

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

**SPECIFY RECORDS:** Check the box, initial and/or sign to specify which type of information is to be disclosed.

- MEDICAL INFORMATION**
- PSYCHIATRIC INFORMATION**
- DRUG/ALCOHOL INFORMATION**
- RESULTS OF AN HIV TEST**
- GENETIC RECORDS**
- OTHER HEALTH INFORMATION**

\_\_\_\_\_ (Initial)

Signature

Date

Signature

Date

Signature

Date

Signature

Date

\_\_\_\_\_ (Initial) (specify below)

Specify the records to be disclosed: **all results from the employer requested evaluation, requested by the above employer**

The recipient may use the health information authorized on this form for the following purposes: **job placement and accommodation**

A copy of this authorization is as valid as the original.

Member/Patient has a right to a copy of this authorization.

Date

Signature

If Signed by Other than Member/Patient, Indicate Relationship