KAISER PERMANENTE®
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
2101 E. Jefferson Street Rockville, MD 20849-6611

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize: Kaiser Permanente
Name of sending person/organization

Street Address

Stockton CA
City State Zip Code

Telephone Number

To disclose to: Tiffany Kay Anderson
Recipient Name

2 N Avena Avenue
Street Address

Lodi CA 95240
City State Zip Code

209-625-8587
Telephone Number

Records and information pertaining to:
Tiffany Anderson 08-22-1970
Name of Member/Patient (List other names used) Date of Birth (MM/DD/YYYY)

07897964 209-625-8587
Medical Record Number / Group # Daytime Phone Number

2 N Avena Avenue
Street Address

Lodi CA 95240
City State Zip Code

Distribution:
☐ Fax Number _____

☒ Mail to Address Above
☒ Pick up in stockton CA only

Media Type:
☒ Paper
☒ Electronic _____

I am requesting: ☒ My records ☐ Records for a Child / Adult for whom I am a legal guardian or personal representative

Specify Records to be Released: (If date below is left blank, a two year period will be disclosed.)

☒ General Medical Information (from 2011 to 2014) + 1990-2014 I do not know Kaiser #
☐ Immunizations (from 1990 to 2014)
☒ Form
☒ Laboratory Results (date) 1990-2014 Name or Type of Test(s): all tests
☒ Radiology Images (exams/dates) 1990-2014 all
☒ Copay Summary for ☒ Pharmacy ☒ Office Visits Calendar Year(s): 1990-2014
☒ Behavioral Health Records (from 2010 to 2014) Signature _____ Date 2-18-14
☒ Sexually Transmitted Disease (from 1990 to 2014) Signature _____ Date 2-18-14
☒ Alcohol/Drug Records (from 1990 to 2014) Signature _____ Date 2-18-14
☒ HIV/AIDS/ARC Records (from 1990 to 2014) Signature _____ Date 2-18-14
☒ Other Records (specify): any and all gyno results, blood work,

Recipient Use: Please describe each purpose of the requested use or disclosure of the health information:
☒ Personal Copy ☒ Continuity of Care ☒ Insurance ☒ Legal/Attorney ☐ Workers' Compensation ☒ Other: _____

Duration: This authorization will remain valid for one year from the date of your signature.

Revocation: I UNDERSTAND that I may revoke this authorization at any time (in writing) except to the extent that action has been taken in reliance on it. To revoke this authorization, please provide a written statement to Kaiser Permanente Health Information Management Services.

Redisclosure: I UNDERSTAND that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected by 45 CFR Subtitle A, Subchapter C, Section 164.500 and 42 CFR Part 2.

Conditions: Kaiser Permanente may not condition treatment, payment, enrollment or eligibility for benefits on my providing or refusing to provide this authorization. **FOR INSURANCE CONTRACTS ISSUED IN THE COMMONWEALTH OF VIRGINIA OR DISTRICT OF COLUMBIA:** I understand that this authorization shall be valid: (a) in the case of authorizations signed for the purpose of collecting information in connection with an application for an insurance policy, a policy reinstatement, or a request for change in policy benefits: (1) Thirty months from the date the authorization is signed if the application or request involves life, accident and sickness, or disability insurance; (b) in the case of authorizations signed for the purpose of collecting information in connection with a claim for benefits under an insurance policy: (1) the term of coverage of the policy if the claim is for an accident and sickness insurance benefit; (2) the duration of the claim if the claim is not for an accident and sickness insurance benefit.

A copy of this authorization is valid as an original. Member/patient has a right to a copy of this authorization.

2-18-14 _____ _____
Date Signature If Signed by Other than Member/Patient, Indicate Relationship

PAYMENT MAY BE REQUIRED BEFORE

March 14, 2014

Dear Kaiser Permanente:

My name is Tiffany Anderson and I had previously ordered my medical records from your facility. I've been told that they are ready to be picked up. I am unable to personally pick these up so I am writing you to give authorization to my agent, Antonio Porras, to pick them up for me within the next five (5) days and pay for any charges incurred. Antonio has my permission to retrieve these medical records for me.

Thank you for your assistance. Please feel free to call me if you have any questions at 209-625-8587.

Tiffany Anderson
8/22/1970