11-22-13
faxed &
spoke to my phone

San Joaquin County Employees' Retirement Association

November 14, 2013

Ms. Tiffany K. Anderson
2 N Avena
Lodi, CA 95242

RE: Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Dear Ms. Anderson:

On April 14, 2003, Health Insurance Portability and Accountability Act of 1996 (HIPAA) was enacted. HIPAA guarantees a patient's right to have his or her health information kept private. In order for San Joaquin County Employees' Retirement Association to obtain your medical records from Kaiser Permanente, Stockton (Orthopedic) you must complete the attached forms.

In order to expedite your disability retirement claim, please complete the attached forms and mail them back to San Joaquin County Employees' Retirement Association as soon as possible.

If you have any further questions, please contact me.

Sincerely,

Beatriz S. Garcia

Beatriz S. Garcia
Retirement Services Technician

Enclosure

6 South El Dorado Street, Suite 400 • Stockton, CA 95202
(209) 468-2163 • Fax (209) 468-0480 • www.sjcera.org

KAISER PERMANENTE®

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

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 ORTHOPEDIC
Name of Disclosing Party

7373 West Lane
Address

Stockton CA 95210
City State ZIP

To disclose to: SJ CERT ATTN: ANNETTE ST. JOSEPH, CEO
Name of Recipient

6 S EL DORADO St. Ste #400
Address

Stockton CA 95202
City State ZIP

If requesting your own records for yourself, specify facilities: —

Records and information pertaining to:
TIFFANY ANDERSON
Name of Member/Patient (List Other Names Used)

Medical Record Number

Date of Birth

2 N ALENA LODI CA 95242
Address

Telephone Number

DURATION: This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here _____ (Date).

REVOCATION: 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.

REDISCLOSURE: 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

_____ (Initial)

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____

Specify the records to be disclosed: ALL medical records

The recipient may use the health information authorized on this form for the following purposes: SSI DISABILITY RETIREMENT APPLICATION

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 _____