Release of Information ( )
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Stapleton Support Services
11000 E.45th Avenue Denver, CO 80239-3004

Forms Processing ( )
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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

1. **I authorize Kaiser Foundation Health Plan of Colorado (KFHP) and/or the Colorado Permanente Medical Group (CPMG) to release the health information of the individual named below:**

   Patient Name:________________________ Kaiser Medical Record #:________________

   Address:________________________ City______________ State_____ Zip Code_______

   Phone#:________________ Date of Birth:____/____/____ SSN:________________

2. **I authorize the information to be disclosed to and used by the following individual or organization:**

   Name:____

   Address:________________________________ Suite # ____________

   City:________________________ State:__________ Zip Code:__________

   Phone #________________________ Fax #________________

   For the purpose of : LIFE INSURANCE

3. **The type and amount of information to be disclosed is as follows:** (*specify dates where appropriate*)

   ☐ Immunizations
   ☐ Most recent 1,3,5 years of Record
   ☐ Entire Medical Record
   ☐ HIV/AIDS information, from date________to date__________
   ☐ Laboratory Results, from date__________to date__________
   ☐ X-Ray Reports, from date__________to date__________
   ☐ Genetic testing, from date__________to date__________
   ☐ Entire Medical Record for Diagnosis of ________________ Treating Physician______________
   for the time period of__________ to ________or when I no longer have diagnosis of ____________.
   ☐ Other ________________ **I will pick up ( ) Mail to:____________ Fax to:____________

4. I understand that the medical information released by this authorization may include information concerning treatment of physical and mental illness, alcohol/drug abuse and past medical history.
5. I understand this authorization will expire, without my express revocation, either one year from the date of signing, or if I am a minor, on the date I become an adult according to state law, whichever occurs first. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on it. I understand that revocation will not apply to information that has already been released as specified by this authorization or to my insurance company when the law provides my insurer with the right to contest a claim under my policy or the policy itself.
6. I understand that authorization for the disclosure of this health information is voluntary and I can refuse to sign this authorization. KFHP/CPMG cannot condition treatment, payment, enrollment in the health plan or eligibility for benefits on the signing of an authorization, except as otherwise permitted by law. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.
7. I accept full financial responsibility for copying fees. Per Colorado Department of Public Health and Environment Regulations, the fee for copying requested documents is $14.00 for the first ten pages, $.50 per page for pages 11 through 40 and $.33 per page for each page over 40. Shipping and applicable sales tax will also be charged. There is no charge for records sent to another health care provider.

______________________________ ______________________
Signature of Patient or Authorized Personal Representative Date

______________________________ ______________________
Personal Representative's Name (print) and Relationship Date
(Please attach applicable legal documentation of authority)

For Office Use:
Verification of PhotoID ________________ Verified By________________