Outside Records Request
Continuation of Care

*This authorization will expire 1 year from date of signature
*Individuals have the right to revoke the authorization by sending a letter expressing revocation to Kaiser Permanente at: 11000 East 45th Ave Denver CO 80239

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI) TO KAISER PERMANENTE
Please disclose the requested PHI of the individual named below for ***continuation of patient treatment***

*****ONE REQUEST PER PATIENT*****

Patient Name:			
KP HRN/MRN:		**Date of Birth:**	

Information Requested From: (Where are your records coming from?)

Provider/Organization:					
Street Address:				**City:**	
State:		**Zip:**		**Phone:**	
Fax:					

The type of information to be disclosed: (What records are needed?)

☐ Most recent ___ (years) of records *** **UP TO 3 YEARS*****			**Most Recent:**
			☐ H&P
☐ Immunizations			☐ Medication List
☐ Growth Charts			☐ PAP
☐ Operative reports			☐ Mammogram
	YEAR		☐ Colonoscopy/Flexible Sigmoidoscopy
☐ Laboratory Results		to present	☐ ECG
☐ Hospital Discharge Summaries		to present	☐ Echocardiogram
☐ Specialty Consults		to present	☐ Spirometry
☐ X-Ray, CT, MRI, and/or PET scan reports		to present	☐ Cardiac Catheterization/Stress testing
			☐ Bone Density
☐ Other:			

Kaiser Permanente prefers to accept records in the following 2 formats

Fax: 1-877-515-0480 **OR** **CD / Thumb drive:** Records Integration 11000 E. 45th Ave Denver Co 80239

Please DO NOT mail records in paper format unless it's your only method

If only method, please mail to: Records Integration 11000 E. 45th Ave Denver Co 80239

NOTE: I understand that the medical information released by this authorization may include information concerning treatment of physical or mental illness, past medical history, alcohol/drug abuse, HIV/AIDS, or other sensitive information.

NOTE: I understand that my medical information may be accessed via health information exchange (HIE) and/or via EPIC Care Everywhere

NOTE: I understand that my medical information may be re-disclosed.

NOTE: I understand that my treatment, payment, enrollment or eligibility of benefits may not be conditioned on obtaining this authorization.

Patient / Guardian / Representative Signature: ______________________________ **Date:** ______________