



AUTHORIZATION FOR DISCLOSURE OF CHEMICAL DEPENDENCY RECORDS FOR BILLING, THIRD PARTY REIMBURSEMENT AND HEALTH CARE OPERATIONS – Page 1 of 3

MR #: _____

Name: _____

IMPRINT AREA

Your decision about whether or not to sign this authorization is completely voluntary, and will not affect your eligibility for future care or membership in Kaiser Foundation Health Plan (KFHP).

What We Are Requesting:

Kaiser Permanente’s Mental Health and Chemical Dependency (MH/CD) Department requests your authorization to share your chemical dependency treatment and payment records with the following entities: KFHP, The Permanente Medical Group (TPMG), Kaiser Foundation Hospitals (KFH), the Centers for Medicare and Medicaid Services (CMS), and third-party payers, including any agent or successor of these organizations.

Why We Are Requesting this Authorization:

Federal law requires your consent for the Kaiser Permanente MH/CD Department to release information about your chemical dependency treatment to persons outside the Kaiser Permanente MH/CD Department, subject to limited exceptions. Written authorization is necessary for Kaiser Permanente to bill for and obtain reimbursement for your care, and to conduct important internal business functions. Information will be shared with KFHP, as needed, to perform certain operational functions within Kaiser Permanente, such as member grievance resolution, quality monitoring, and compliance activities. We will only share the minimal amount of CD Information, that, in our professional judgment, is necessary for the billing and operational purposes described above. Such entities may disclose CD Information among each other for these purposes.

We encourage you to authorize release because your authorization is necessary for Kaiser Permanente to receive payment for services and to conduct health care operations. If, at any time, you have concerns about your privacy, you are encouraged to request clarification from your therapist or a staff member.

Authorization to Release Your Chemical Dependency Information

To acknowledge the release of your chemical dependency treatment and payment records, please select **one** of the following Options under CD Information **and** complete the authorization section (Option A).

CD Information:

- Option #1 All Medical and Claims/Encounter and Payment Records
- Option #2 Medical Records Only
- Option #3 Claims/Encounter and Payment Records Only



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Option A:

Authorization to Release Your Chemical Dependency Information

By signing your name in the space below, you acknowledge and agree that you have read and understood this document and authorize Kaiser Permanente's MH/CD Department to share all or any portion of chemical dependency diagnoses, and/or records relating to your chemical dependency treatment/procedures with KFHP, TPMG, KFH, CMS and third-party payers, including any successor or agent of these organizations, as necessary to accurately document, audit, and receive reimbursement for your care. Information will be shared with KFHP to perform certain operational functions within Kaiser Permanente, such as member grievance resolution, quality monitoring and compliance activities. Such entities may disclose CD Information among each other for these purposes.

My third party payer(s) are: _____

I will inform the MH/CD Department if my third-party payer changes so that I may execute an updated consent. (Note: If the person receiving care is a minor, then a parent or legal guardian acknowledges having read and understood this document and authorizes such release. Both the minor and the parent/legal guardian must sign below. Under certain circumstances, minors may consent to treatment and authorize the release of information regarding their treatment themselves without parental permission, in which case only the minor must sign below.)

Patient's Name (print) Signature Date

Name of Patient's Parent/Guardian (print) Signature Date
(where required)

Name of Person Authorized by Law Signature Date
to Sign on Behalf of Patient (print)
(where required)

If you are under the age of 18, your signature immediately below signifies your consent for us to share with your parent or guardian the fact that you have applied for chemical dependency treatment so that we may request your parent or guardian to sign this authorization.

Minor Patient's Name (print) Signature Date
(where required)

About this Authorization Request

You or your personal representative may cancel this authorization for future releases by submitting a written request to the Release of Medical Information Department at any Northern California Kaiser Permanente Medical Center. Your cancellation will not affect information that was released prior to receipt of the written request. Once we receive your revocation, the MH/CD Department will no longer disclose your CD Information and/or diagnoses to TPMG, KFH, KFHP, and third-party payers or their agents, except for the information already disclosed during the time when we had your permission or when the law allows us to disclose the information without your permission.

This authorization will remain effective so long as your medical record is an active medical record in the Kaiser Permanente record system and we believe such authorization is necessary to accurately document, audit, receive reimbursement for your care or conduct operations internal to Kaiser Permanente.

