KAISER PERMANENTE®

DIABLO SERVICE AREA

REQUEST TO RELEASE HEALTH INFORMATION FOR SECOND OPINION

Patient Name: _____

Kaiser #: _____

Telephone Number: (____) _____

May we leave a voice message at your telephone number? ❑ Yes ❑ No Verified by: _____

PLEASE PRINT CLEARLY

To process your request in a timely manner, please be sure to fill out this form completely and submit via:
Hand deliver to Intake Window or
Fax to Medical Secretaries Department at 1-877-883-5917 or

Kaiser Permanente may disclose the medical information to:

Medical Center: _____

Department: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Contact Name: _____

Contact Telephone Number: (____) _____ Fax Number: (____) _____

Specify the health information needed for your second opinion:

❑ Medical office visits dated from: _____ to _____

❑ Hospital medical records dated from: _____ to _____

❑ X-Ray dated from: _____ to _____

❑ Images on CD dated from: _____ to _____

❑ Reports dated from: _____ to _____

❑ Pathology slides dated from: _____ to _____

Description of health condition: _____

_____

_____

Specify your media preference:

❑ Paper ❑ CD (if available electronically)

Specify your delivery preference:

❑ Pickup/Hand Carry (Recommended)

❑ Mail (NOTE: Pathology slides cannot be mailed)

❑ E-mail: _____

For Pickup/Hand Carry only, select the Intake Window location:

❑ Antioch Medical Center

❑ Delta Fair Medical Offices

❑ Livermore Medical Offices

❑ Martinez Medical Offices

❑ Park Shadelands Medical Offices

❑ Pleasanton Medical Offices

❑ Walnut Creek Medical Center

_____ _____

Date **Signature**