KAISER PERMANENTE®

Authorization Form Guidelines

Guidelines for preparing an authorization form for use by employers who seek to represent their employees in claims and other issues with the Health Plan.

1. In the absence of an acceptable authorization from an employer, Health Plan cannot share health or claims information about an individual member with the employer. The following material can be used as the basis for developing a standardized authorization/representation form for employers seeking to represent their employees in claims/grievances and related disputes.

2. The authorization –

Must include this statement –

I authorize Kaiser Foundation Health Plan, Inc. to disclose health information, including information about health care I have received or will receive and about payment by me or someone on my behalf, that may identify me (Protected Health Information or PHI). This information, which is described below, may be disclosed to _____[fill in name of employer/other party]_____ ("Designated Representative").

Must include a statement something like the following –

The specific PHI that I authorize Kaiser Foundation Health Plan to disclose to my Designated Representative is:

(Please check the appropriate box)

Information that I have filed with Kaiser Foundation for the claim identified in this authorization, and information used by Kaiser Foundation Health Plan in reviewing that claim.

Other (Please indicate specific information, for example: Evidence of Benefits payment statements, claims information, provider reports, etc.)

This authorization allows my PHI to be disclosed to my Designated Representative only for the following purpose(s): (Please check the appropriate box)

To ONLY resolve the issue(s) relating to the claim(s) I have filed as identified in this authorization

Other (Please describe the specific uses and disclosures)_____
_____

This authorization expires on: (Please check the appropriate box)

Date (Please specify date)_____

Resolution of the issue(s) identified in this authorization

Other (Please Describe the Event that Terminates this Authorization_____

_____

3. This statement must be included in the authorization

I understand that:

(1) PHI disclosed in reliance on this authorization may be re-disclosed and may no longer be protected by the Health Insurance Portability and Accountability Act of 1996.

(2) I have the right to revoke this authorization. If I choose to do so, I must send a written revocation of this authorization to Kaiser Foundation Health Plan and to my Designated Representative. Kaiser Foundation Health Plan and my Designated Representative will no longer use or disclose my PHI, except to the extent Kaiser Foundation Health Plan or my Designated Representative has taken action in reliance upon this Authorization.

(3) This Authorization is voluntary. I understand that I may refuse to sign this authorization. My Designated Representative may not require me to sign this authorization, and my refusal to sign will not affect my eligibility for benefits from my Designated Representative or my enrollment in or coverage under my Designated Representative's group health plan.

4. There must be a line for the name, the date and the signature of the individual, with this statement.

I have made this request for release of my PHI to my Designated Representative.

_____ _____

Print Name Date

_____

Signature

5. If a Personal Representative of the member/patient executes the form, that Personal Representative must warrant that he or she has authority to sign the form on the basis of:

Legal Authority (Power of Attorney, etc.)
Parent, Guardian or other individual acting in loco parentis
Written Designation by the Participant

6. There must be a line for the name, the date and the signature of the representative.

I am authorized to sign this authorization on behalf of _____(member/patient)_____.

_____ _____
Print Name Date

_____
Signature

7. It is important that the authorization be made specific to the claim or information sought. Thus the form should request additional information from the member. It can include –

Group Name Group Number Contract Number Medicare Number (if applicable)

Patient's Name Subscriber's Name Relationship to Subscriber Self Spouse Dependent Telephone Number ( ) Address City/State Zip Code

Claim Detail Section

Date(s) of Service

Location of Service

Type(s) of Service

To assist us in releasing your PHI, please summarize the issue(s) and action(s) desired. Describe other relevant information that you feel Kaiser Foundation Health Plan should send to your Designated Representative.

_____
_____
_____
_____

8. Another possible field for the form is –

Provider Information Section

Provider's Name
Provider's Address

9. If this is a two sided form – or two pages - this statement should appear on the same page as the information requested under numbers 7 and 8 –

In Order for This Form to be Effective, You Must Complete the Authorization Section and sign it on the appropriate line.