Kaizen Psychiatric Services
14845 SW Murray Scholls Dr, Ste 110 PMB 412
Beaverton, OR - 97007-9237

Release of Information

RELEASE OF INFORMATION

I understand the following information:

I have the right to refuse to sign this form for authorization to disclose or release my protected health information. Refusal to sign the authorization will not adversely affect my ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign this authorization may affect my ability to receive health care services is if the health care services are research-related or solely for the purpose of providing health information to someone else and the authorization is needed to make that disclosure.

There may be a fee associated with this request (if you are requesting paper or digital copies of your records)- please ask for specifics about price.

Information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS, mental health information, genetic testing information and drug/alcohol diagnosis, treatment, or referral information.

I have the right to receive a copy of this signed authorization.

Unless revoked, this authorization expires when you are no longer a patient at Kaizen Collective. I may revoke this authorization in writing at any time. If I revoke this authorization, the information described below may no longer be used or disclosed for the purposes described in the written authorization. The only exception is when Kaizen Psychiatric Services LLC also know as Kaizen Collective have taken action in reliance on the authorization or the authorization was obtained as a condition of insurance coverage.

To revoke this authorization, send (email, fax or postal mail) a written statement that you are revoking this authorization along with a copy of this authorization to:

Kaizen Collective
Email: info@kaizenpsychiatric.com
Fax: (618) 822-4174

Mailing Address:

14845 SW Murray Scholls Dr
Suite 110 - 412
Beaverton, Oregon 97007

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Is there a family member, friend, spouse, partner or other individual who should be able to share information for your care? This includes making appointments, requesting refills, sending messages on your behalf, texting, making phone calls, getting your lab orders or or getting your lab results. If you say yes, you will be ask to give us some information below. If you say no, we will not share your information with any. *

☐ Yes ☐ No

Who can we talk to about your care? If you have more than one person, please request another release of information form

Relationship to You

☐ Emergency Contact ☐ Partner/Spouse ☐ Family Member ☐ Friend ☐ Parent

Are they your medical power of attorney?

☐ Yes ☐ No

Do they have the ability to make medical decisions for you, the minor patient, and/or ward?

☐ Yes ☐ No

I want you to share the following information:

☐ All of my or the patient's health information ☐ Only talk to them in emergencies ☐ My therapy information ☐ Discuss medications and refills

Describe specific release situations below if it is your emergency contact, write "emergency contact only": *

Term

I agree that this Authorization will remain in effect as long as I am a patient at Kaizen Collective unless I specifically revoke or change this consent in writing.

Redisclosure

I understand that my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Refusal to sign/right to revoke

I understand that signing this form is voluntary and that if I don't sign this form, it will not affect the commencement, continuation or quality of my treatment. If I change my mind, I understand that I can revoke this authorization by providing a written notice of revocation. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation. I understand that I will need to revoke this form in writing through e-mail or the patient portal. Simply texting the office will not be sufficient to revoke this authorization.

Release of Information Signed on: * _____

Relationship to Patient * _____

PATIENT SIGNATURE * _____