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

Release of Records.2024

AUTHORIZATION TO USE, DISCLOSE & RELEASE PROTECTED HEALTH INFORMATION

Purpose of Sharing Information:

Your Provider is asking for permission to share records, talk with your other providers, review past treatment or coordinate care. Sharing information from current Providers or past Providers is important to your care. Sharing allows your current Providers to make better decisions, work together with your other providers and get a better overall view of your physical and mental health.

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- 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 in 180 days. 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

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

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

Mailing Address:

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

I am aware that withholding medical or psychiatric information may result in ineffective care, endanger my life or cause harm. *

Provider and Clinic Name *

Provider or Clinic Office Number *

Provider or Clinic Fax Number. If you do not know or can not find the fax number, please put the link for the Provider/ Clinic's website here. *

Provider or Clinic Address (including city, state, and zip)

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I authorize the release of the following health information (please check all that apply). Please select "ALL PAST MEDICAL RECORDS FOR COORDINATION OF CARE OR TRANSFER/ REFERRAL FOR CARE" if we are requesting test results, lab work, notes, etc...from other offices. *

- ☐ ALL PAST MEDICAL RECORDS FOR COORDINATION OF CARE OR TRANSFER/ REFERRAL FOR CARE
- ☐ ALL PAST MEDICAL OR MENTAL HEALTH RECORDS including lab work, treatment notes, referrals, medication records, physical health records, and any other piece of information about my care with the Provider or Clinic I listed.
- ☐ Medical Hospitalization, Psychiatric Hospitalization, IOP/ PHP or Emergency room records
- ☐ Addiction Recovery Treatment Records including diversion
- ☐ Information about an arrest or incarceration.
- ☐ Information from Child and Family Services about removal of children, foster care or adoption
- ☐ Information about treatment for an infections disease including HIV/AIDS
- ☐ Genetic testing information
- ☐ Care Summary Including a diagnosis, list of appointments, medications and any testing results to a Probation/Parole Officer or other Case Worker including Child and Family Services

If records are to be released to a probationary or parole office, or case worker, please list their name below:

If you do not select an option OR select more than one option, this authorization will remain in effect while you are a patient at Kaizen Collective.

- ☐ Until my treatment at Kaizen Collective is complete
- ☐ Until my treatment with the Provider or Clinic listed above is complete
- ☐ Until records of previous treatment are received by Kaizen Collective
- ☐ Until a specific date:

Authorization Expiration Date: _____

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.

Release of Records Signed on: * _____

Relationship to Patient * _____

PATIENT SIGNATURE * _____