mindful therapy group

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Instructions: This form must be completed for any person or organization that you want Mindful Therapy Group to be able to share scheduling, billing, payment, or clinical information with. If you will be handling all coordination of your care independently, then in most cases a Release of Information (ROI) does not need to be completed. **This form must be completed and signed by the individual who has legal authority to authorize the disclosure.**

Important for Clients Aged 14-17: Under Oregon state law, adolescents age 14 and older may consent to their own outpatient behavioral health or substance-use treatment. When an adolescent self-consents, they also control who may access their health information.

If the adolescent has self-consented to treatment: The adolescent must sign this ROI for MTG to share any scheduling, billing, or clinical information with a parent/guardian or anyone else. Without an ROI, MTG generally **cannot acknowledge** that the adolescent is a client or discuss their care with a parent/guardian.

- Oregon law requires providers to **attempt to involve a parent/guardian before the end of treatment**, unless clinically inappropriate or the parent/guardian refuses. Involvement does not necessarily mean full access to treatment records.

If the parent/guardian is consenting to the adolescent's treatment: The parent or guardian may sign the ROI on behalf of the minor, unless the adolescent is receiving treatment under their own consent rights.

Safety Exceptions: MTG may disclose limited information to a parent/guardian without adolescent authorization if necessary to protect the adolescent's safety, such as in cases of serious and imminent risk of harm, need for inpatient/detox services, or when disclosure is otherwise clinically appropriate and in the minor's best interest.

For more information on Oregon law, please refer to ORS 109.675 and ORS 109.680.

For any additional questions regarding this form, please review our Release of Information FAQ page on the Mindful Therapy Group

Patient Name:
DOB:

At my request, I hereby authorize Mindful Therapy Group, P.C. and my mental health provider(s), to disclose and receive my private health information with the recipient specified below.

Please check and fill in selections below:

My entire treatment record (this is limited to your clinical records; it does not include billing information, scheduling, appointment details, nor patient portal access): ☐
Billing information, including dates of service, diagnostic codes, and procedure codes: ☐
Scheduling and Appointment Details: ☐
Patient Portal Access (billing statements, appointments, and progress notes will be viewable): ☐

Records from a specific timeframe:
Other:

All of the above: ☐

Information to be exchanged with:

Name of external facility or individual:

Relationship to Client:

Address:

Fax:

Phone:

Email:

Unless specified otherwise below, this authorization of disclosure of my health information will expire at the conclusion of my treatment with Mindful Therapy Group.

Optional specific expiration date or event:

I understand and agree that:

- This authorization is voluntary;
- My health information may contain information created by other persons or entities including health care providers and may contain medical, pharmacy, dental, vision, mental health, substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease and health care program information;

- I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment by my health care provider, except to the extent that the information being requested may assist your health care provider in determining appropriate treatment.
- My health information may be subject to re-disclosure by the recipient, and if the recipient is not a health plan or health care provider, the information may no longer be protected by the federal privacy regulations;
- I may revoke this authorization at any time by notifying my provider in writing; however, the revocation will not have an effect on any actions taken prior to the date my revocation is received and processed nor future disclosures to the extent that action has already been taken in reliance on this authorization.

Authorization:
Signature of Patient or Authorized Representative:

Date:

Relationship if not Patient: