

PATIENT INFORMATION

PLEASE PRINT

Full Name (include middle initial)

Date

Address

City/State/Zip

Phone

Date of Birth

Social Security Number

JONATHAN COLLIN, MD

911 Tyler Street
Port Townsend, Washington 98368
(360) 385-4555
Fax (360) 385-0699

Authorization to Release Healthcare Information

I hereby request and authorize the following release of information:

Information to be released by:

Doctor or Hospital

Address

City/State/Zip

Phone

Purpose of Disclosure: Review of records for medical treatment

Legal Insurance At patient request for patient use

Other (explain)

Information to be released to:

checkbox

JONATHAN COLLIN, MD
911 Tyler Street, Port Townsend WA 98368
(360) 385-4555 • Fax (360) 385-0699
Tax ID #91-1150265 / UPIN A04297

checkbox

Name

Address

City/State/Zip

Release Requiring Specific Consent:

My initials and signature below authorize the release of healthcare information relating to testing, diagnosis or treatment for:

HIV/AIDS

Sexually Transmitted Diseases

Reproductive Care (minors only)

Mental Health

Alcohol/Drug Abuse

Minors - A minor patient's signature is required in order to release the following information (1) conditions relating to a minor's reproductive care including, but not limited to, contraception, pregnancy and pregnancy termination, sterilization, and sexually transmitted diseases (age 14 and older), (2) alcohol and/or drug abuse (age 13 and older), and (3) mental health conditions (age 13 and older).

Check if patient is a minor

General Medical Information:

Dates: From/To

Clinic Records

Lab Results

Radiology Reports

Radiology Films

Home Care Records

Hospital Records

Skilled Nursing Facility Records

Other

Signature of patient or patient's authorized representative

Relationship to patient (if not patient)

Date

Signature of patient or patient's authorized representative

Relationship to patient (if not patient)

Date

I understand that I do not have to sign this authorization in order to get health care benefit (treatment, payment, enrollment or eligibility for benefits) except if I receive healthcare when the sole purpose of the healthcare is to create health information for a third party.

I understand that: a) I must revoke my authorization in writing; b) If I revoke my authorization, it will not affect any actions already taken by Dr. Jonathan Collin based upon this authorization; and c) I may not be able to revoke this authorization if the purpose of it was to obtain insurance.

Once Dr. Collin has disclosed health information, the recipient may re-disclose it in some situations. Privacy laws may no longer protect the information. I understand that this authorization does not permit the release of information related to health care provided to me more than ninety days after the date of this authorization. This prohibition does not extend to insurance companies.

This authorization expires (date or event). Authorization will expire in ninety days if not otherwise specified.