JONATHAN COLLIN, MD
12911 - 120th Ave. NE #A-50
Mailing Address
[redacted] • Kirkland, WA 98034
(425) 820-0547 • Fax (425) 820-0259

Authorization to Release Healthcare Information

PATIENT INFORMATION

PLEASE PRINT

Full Name (include middle initial) _____ Date _____

Address _____

City/State/Zip _____

Phone _____

Date of Birth _____ Social Security Number _____

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) _____

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

Information to be released to:

❑ **JONATHAN COLLIN, MD**
P.O. Box 8099, Kirkland, WA 98034
(425) 820-0547 • Fax (425) 820-0259
Tax ID #91-1150265 / UPIN A04297

❑ 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

_____
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.