Authorization to Release Health Care Information

Patient Name: ______________________________Date of Birth: ___________________

I hereby request and authorize the following release of information :

Information to be released to:	Information to be released by:
Provider: Titan Healthcare	________________________________
Address: 2612 Yelm Hwy SE	_________________________________
Olympia, WA 98501	_________________________________
Phone: 360-507-8146	_________________________________
Fax: 360-839-2852	_________________________________

Purpose of disclosure: ___Continuing care ____ Legal ___ Insurance ___ Patient request

Other: ____

Clinic Records _______________________

Lab Results _______________________

Radiology Reports _______________________

Hospital Records _______________________

Other _______________________

___________ ____________________________________ ____________

Date Signature of patient or patient's authorized representative Relationship to patient

Release requiring specific consent:
My signature below authorizes the release of health care information relating to testing, diagnosis or treatment for: HIV/AIDS, Mental Health, Sexually transmitted diseases, Alcohol/Drug Abuse, Reproductive Care (minors only)

______________ _______________________________________ ________________

Date Signature of patient or patient's authorized representative Relationship to patient

I understand that I do not have to sign this authorization in order to get health care benefits. I understand that I must revoke my authorization in writing. If I revoke my authorization, it will not affect any actions already taken by the office based upon this authorization and I may not be able to revoke this authorization if the purpose of it was to obtain insurance.

This authorization expires in ninety days.