

Yakima Women's Health, PLLC Authorization for access to the medical records of :

Last name	First Name	Date of Birth
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Patient ID Number	SS#	Former Names
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Request Information from:

Clinic Name/ Doctor	Phone Number	Fax Number
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Address	City	State	Zip Code
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Release Information to:

Jacintha L Raj, MD Erin Hepner, ARNP		
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Organization Yakima Women's Health, PLLC	Phone Number (509) 966-3969	Fax Number (509)966-3979
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Address 1020 S. 40 TH AVE Suite C	City Yakima	State WA	Zip Code 98908
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Reason for release:

Authorization for release:

I authorize the following services and or programs to release information from my records. I understand that medical information may be provided orally, by mail, or fax, or hand delivery.

- All medical records
 Specific information or Date of Service _____

NOTE* State law requires that you give specific permission to release the information below even if you checked a box above. Indicate your permission for the following information by initialing all that apply.

Genetic Information _____ (Initials) HIV/AIDS _____ (Initials)

STD/Cervical Cancer testing _____ (Initials) Mental/Behavior Health _____ (Initials)

I understand and agree to the release of medical information authorized in the form. This consent is valid for ninety (90) days or upon expiration at stated in the authorization, which ever is earlier. I understand I may revoke this release in writing at any time, but I understand that revocation will not affect any information that was already released. A copy of this form is valid to give my permission to release records.

Patient Signature	Date signed
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Print Name	Witness
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