Yakima Womens Health, PLLC - Authorization for access to the medical records of :			
Last name	First Name		Date of Birth
Patient ID Number	SS#		Former Names
Request Information from:			
Clinic Name/ Doctor	Phone Number		Fax Number
Address	City	State	Zip Code
Release Information to:			
Jacintha L. Raj MD			
Organization:	Phone Number:		Fax Number:
Yakima Women's Health, PLLC	**(509) 966-3969**		**(509)966-3979**
Address:	City:	State:	Zip Code:
1020 S. 40th Ave. Suite C	**Yakima**	**WA**	**98908**
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, 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 this form. This consent is valid for ninety (90) days or upon expiration date stated in the authorization, whichever 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
Print Name	Witness