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Yakima Vascular Associates  
3999 Englewood Avenue, Suite 202, Yakima, WA 98902 • Phone – 509.453.4614 • Fax – 509.453.3468

**AUTHORIZATION TO RELEASE INFORMATION TO DESIGNATED INDIVIDUALS**

I, \_\_\_\_\_ (Patient's name printed)

Authorize Yakima Vascular Associates to release any medical and/or billing information to:

<b>Individual</b>	<b>Relationship</b>	<b>Date of Birth</b>	<b>SSN</b>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

This authorization may be revoked in writing at any time. However, a revocation would not affect any actions already taken by Yakima Vascular Associates based upon this authorization.

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Signature of Patient or Patient's Representative	Date	Date of Birth
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Printed Name of Patient's Representative (if applicable)