

**CONSENT TO RELEASE INFORMATION**

I, GIVE THE PHYSICIANS AND OFFICE STAFF OF WESTERN WASHINGTON MEDICAL GROUP, DEPARTMENT OF SURGERY, PERMISSION TO DISCUSS MY MEDICAL CONDITION (**PLEASE LIST FAMILY MEMBERS & FRIENDS ONLY**),

WITH: \_\_\_\_\_

WHO IS \_\_\_\_\_ AT PH# \_\_\_\_\_  
(RELATIONSHIP)

AND/OR \_\_\_\_\_

WHO IS \_\_\_\_\_ AT PH# \_\_\_\_\_  
(RELATIONSHIP)

AND/OR \_\_\_\_\_

WHO IS \_\_\_\_\_ AT PH# \_\_\_\_\_  
(RELATIONSHIP)

AND/OR \_\_\_\_\_

WHO IS \_\_\_\_\_ AT PH# \_\_\_\_\_  
(RELATIONSHIP)

**THIS IS AN INDEFINITE CONSENT FORM UNLESS OTHERWISE SPECIFIED.**

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
DATE