**Matthew Ashbach, M.D.**
**Rebecca Epperson, A.R.N.P.**
**Erin Robinson, M.A. FAAA**

# Acknowledgement of Receipt of Notice of Privacy Practices Form

By my signature below, I, ________________________________ , acknowledge that I received a copy of the Notice of Privacy Practices for Western Washington Medical Group.

_______________________________________________ _________________________________

Signature of patient (or personal representative) Date

**If this acknowledgement is signed by a personal representative on behalf of the client, complete the following:**

Personal Representative's Name: ________________________________________________________

Relationship to Patient: ________________________________________________________________

## For Office Use Only

I attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign
_____ Communications barriers prohibited obtaining the acknowledgement
_____ An emergency situation prevented us from obtaining acknowledgement
_____ Other (Please Specify)

__________________________________________________________________________________________
__________________________________________________________________________________________

_______________________________________________ _________________________________

Employee Name Date

This form will be retained in your medical record

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# Consent to Release Information – Family and Friends

I give the providers and office staff of Western Washington Medical Group (WWMG) permission to discuss my medical condition. (*NOTE: if a specific topic box is not checked, we will be unable to discuss any treatment related to that topic*.) **WWMG may disclose health care information regarding testing, diagnosis and treatment for the following conditions:**

[ ] HIV (Aids virus)
[ ] Sexually Transmitted Infections (STIs)
[ ] Psychiatric disorders / Mental health
[ ] Alcohol / Substance abuse
[ ] All other health information
Other: ______________________________________________

The consent will be considered valid until such time that I revoke it. I reserve the right to revoke it at any time. It will be my responsibility to keep this information current, as I recognize that relationships and friendships change over time.

| *Name* | *Relationship* | *Phone* |
|---|---|---|
| *Name* | *Relationship* | *Phone* |
| *Name* | *Relationship* | *Phone* |

**Patient's Personal Phone Information: NOTE! This is DIFFERENT than the above info.**

Please provide us with **YOUR best, most current** phone contact information. This information will become part of your permanent medical records *unless/until you change it*. You can change this information simply by asking to complete a new form.

**Please note: by approving the option to leave a detailed message, you are allowing us to leave sensitive health information and specifics related to referrals.**

| **First phone number** | **Second phone number** | **Third phone number** |
|---|---|---|
| Cell Work Home<br>OK to leave detailed message: Y N | Cell Work Home<br>OK to leave detailed message: Y N | Cell Work Home<br>OK to leave detailed message: Y N |

________________________________ ________________
*Signature of patient (or personal representative)* *Date*

**If this acknowledgement is signed by a personal representative on behalf of the client, complete the following:**

________________________________ ________________
*Personal Representative's Name* *Relationship to Patient*