CONSENT TO RELEASE INFORMATION

(FAMILY AND FRIENDS)

I give the physicians 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 <u>any</u> 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*

<u>Patient's Personal Phone Information: NOTE! This is DIFFERENT than the above info.</u>
Please provide us with **YOUR best, most** current phone contact information. This information will become part of your permanent medical record *<u>unless/until you change it.</u>* 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 OK to leave detailed message?: Y N	Cell Work Home OK to leave detailed message?: Y N	Cell Work Home OK to leave detailed message?: Y N

_____ _____
Signature of client (or personal representative) *Date*

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

_____ _____
Personal Representative's Name *Relationship to Client*