CONSENT TO RELEASE INFORMATION

I, ____, GIVE THE PHYSICIANS AND OFFICE STAFF OF WESTERN WASHINGTON MEDICAL GROUP, DEPARTMENT OF CARDIOLOGY, PERMISSION TO DISCUSS MY MEDICAL CONDITION (PLEASE LIST FAMILY MEMBERS AND 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