Western Washington Medical Group

CONSENT TO RELEASE INFORMATION

(FAMILY AND FRIENDS)

I, GIVE THE PHYSICIANS AND OFFICE STAFF OF WESTERN WASHINGTON MEDICAL GROUP, PERMISSION TO DISCUSS MY MEDICAL CONDITION **(PLEASE LIST FAMILY MEMBERS & FRIENDS ONLY); You may disclose health care information regarding testing, diagnosis, and treatment for the following:**

Please check all that apply: ____HIV (Aids virus) ____Sexually transmitted diseases

____Psychiatric disorders/mental health ____Drug and/or alcohol use

All health care information_____

Health care in my medical record related to the following treatment or condition: _____

_____

Health care information in my medical records for the date(s):_____

Other (e.g., x-rays, bills) specify date(s):_____

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_____