Western Washington Medical Group
Urology

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.

WWMG may disclose health care information regarding testing, diagnosis and treatment for the following conditions:
(NOTE: if a specific topic box is not checked, we will be unable to discuss <u>any</u> treatment related to that topic)

[ ] HIV (Aids virus)

[ ] Sexually Transmitted Diseases (STD's)

[ ] Psychiatric disorders/Mental health

[ ] Alcohol/Substance abuse

[ ] All other Health Information

Other: _____

WWMG may disclose this information to the following individuals:
(Please list family members and friends only)

NAME: _____

RELATIONSHIP: _____ PHONE: _____

NAME: _____

RELATIONSHIP: _____ PHONE: _____

NAME: _____

RELATIONSHIP: _____ PHONE: _____

This is an indefinite consent form unless otherwise specified

_____ _____

Signature Date