



Consent to Release Information - Family and Friends

Name: _____

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:**

- | | |
|--|---|
| <input type="checkbox"/> HIV (Aids virus) | <input type="checkbox"/> Sexually Transmitted Infections (STIs) |
| <input type="checkbox"/> Psychiatric disorders / Mental health | <input type="checkbox"/> Alcohol / Substance abuse |
| <input type="checkbox"/> 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
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Name	Relationship	Phone
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Name	Relationship	Phone
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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 record 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 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