Western Washington Medical Group

WWMG
1728 W Marine View Drive #110, Everett, WA 98201
(425) 259-4041 Fax: (425) 252-6642

Registration Form Packet

Name: _____ DOB: _____ MRN: _____

Consent to Release Information to Friends and Family

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 <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**
Check one: Cell Work Home OK to leave detailed message?: Y N	Check one:Cell Work Home OK to leave detailed message?: Y N	Check one: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*