Western Washington Medical Group
Ear, Nose & Throat, Allergy & Audiology

CONSENT TO RELEASE INFORMATION – 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 any 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*

_____ _____
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*