Western Washington Medical Group

Whitehorse Family Medicine

# 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/WFM 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**

**Printed** Patient's name: _____

_____ _____

Signature Date