



CONSENT TO RELEASE INFORMATION

(FAMILY AND FRIENDS)

I, GIVE THE PHYSICIANS AND OFFICE STAFF OF WESTERN WASHINGTON MEDICAL GROUP, PERMISSION TO DISCUSS MY MEDICAL CONDITION (**PLEASE LIST FAMILY MEMBERS & FRIENDS ONLY**); You may disclose health care information regarding testing, diagnosis, and treatment for the following:

Please check all that apply: HIV (Aids virus) Sexually transmitted diseases

Psychiatric disorders/mental health Drug and/or alcohol use

All health care information _____

Health care in my medical record related to the following treatment or condition: _____

Health care information in my medical records for the date(s): _____

Other (e.g., x-rays, bills) specify date(s): _____

WITH: _____

WHO IS _____ AT PH# _____
(RELATIONSHIP)

AND/OR _____

WHO IS _____ AT PH# _____
(RELATIONSHIP)

AND/OR _____

WHO IS _____ AT PH# _____
(RELATIONSHIP)

AND/OR _____

WHO IS _____ AT PH# _____
(RELATIONSHIP)

THIS IS AN INDEFINITE CONSENT FORM UNLESS OTHERWISE SPECIFIED

PATIENT SIGNATURE _____ DATE _____