Stanford HEALTH CARE

University HealthCare Alliance

## Patient's / Patient's Guardian's Consent for Practice to Share Protected Health Information with Other Named Parties

In addition to our normal operational disclosures of privacy information, please identify who we may release your healthcare information to. Each name must be identified. These should be people who help you with your healthcare needs and may need to be knowledgeable about your condition, treatment and options. It is still the responsibility of the below named parties to request this information.

| Name | Relationship |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Patient Signature:_____

Date: _____