Stanford HEALTH CARE

Patient Label
Name
DOB:

Consent to the Use and Disclosure of Health Information

I authorize my medical information to be discussed/verbally disclosed to:

☐ Outside Provider (name) _____

☐ Outside Provider (name) _____

☐ Family member or friend (name) _____

☐ Family member or friend (name) _____

☐ Other (name) _____

Detailed messages regarding test results can be left on answering machine or voice mail:

☐ Yes ☐ No Phone # _____

* ☐ Do not disclose medical information other than to the patient

_____ _____

Signature of Patient or Legal Representative Date

University HealthCare Alliance ("UHA") is a medical foundation affiliated with Stanford HealthCare and Stanford medicine. UHA contracts with several physician groups to provide the medical care in the UHA clinics. Neither UHA, Stanford HealthCare nor Stanford University employ the physicians in the clinics and do not exercise control over the professional serviced provided by the physician group.