PATIENT NAME
DOB

Arrival Label

Stanford HEALTH CARE

University Healthcare Alliance

SIGNED AUTHORIZATION: PLEASE FILL OUT COMPLETELY

Medical information can be discussed with:

_____ Patient Only

_____ Family member or friend (Name & Relationship) _____

_____ Phone # _____

Detailed messages regarding test results, appointment, and billing concerns, can be left on my answering machine/voicemail: No ____ Yes ____

Appointment reminders can be left on my voicemail: No ____ Yes ____

_____ _____

Signature/Patient or Responsible Party Date