Staff, place patient sticker here

Stanford Children's Health
Stanford | MEDICINE
Altos Oaks Medical Group

Permission to discuss Private Health Information

I, _____ give permission to Stanford Medicine - Altos Oaks Medical Group to discuss my Private Health Information (including information on test results, billing/financial information, pregnancy, fertility, mental health, sexually transmitted infections, drug and alcohol use, and physical and/or sexual abuse) to the following people. I understand that I can change and/or revoke this permission at any time.

_____	_____	_____
Printed name	DOB	Relation to Patient
_____	_____	_____
Printed name	DOB	Relation to Patient

_____	_____	_____
Patient signature	Date	Time

Permission expires: _____
Date