Letter of Authorization for Product Pick-up

For Product:_____

Instructions for the patient and the designated person authorized to pick up this product:

Please fill in the blanks on this form and present it to the Transfusion Medicine Services staff when you pick up the product.

Patient's Name: _____

Patient's Date of Birth: _____

Patient's PHN: _____

Signature of Patient or Guardian: _____

The above named patient has authorized the following individual to pick up this product:

Designate's Name: _____

Designate's Date of Birth: _____

Signature of Designate: _____