**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 Laboratory staff when you pick up the product.

**Patient’s Name:**

**Patient’s Date of Birth:**

**Patient’s Health number:**

**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**:

 Designate identification verified