Patient Name: ______________________________

Date of Birth: _________________________

Permission to Disclose Private Health Information (PHI)

By signing below, I give permission to the person(s) listed to receive Private Health Information or other authorization as listed. I understand this form is legally binding and that I may revoke my authorization at any time by submitting, by request, to change, add, or terminate such permission in writing.

NAME	RELATIONSHIP	PHONE NUMBER

ADVANCE CARE PLAN

Do you have an advance care plan or directive? ____

Who is your surrogate decision maker? ____________________________ Relationship: ________________

Would you like further information on creating a plan? ☐Yes ☐No

Signature of Patient or Guardian: _________________________________ Date: ___________________