Crowley Medical Associates

Advance Directive "YOUR RIGHT TO DECIDE"

While you cannot remove all uncertainty about your future healthcare needs, having an ADVANCE DIRECTIVE in place can give you the peace of mind that comes from making your wishes known in advance. The privacy of your health care information is important to us. Once this form is completed, we can verify your request, adjust our records accordingly, and speak to your personal representative.

- **Living Will**

□ I **HAVE** a living will □ I have **NOT** made a living will

- **Health Care Representative**

□ I **HAVE** a designated Health Care Representative □ I have **NOT** designated a Health Care

If you have signed an advance directive outlining your wishes, we will gladly make a copy and place it in your chart. If you have not created an advance directive, we will gladly provide you with information and forms.

Please list the family members or other persons, if any, whom we may **verbally** inform about your general medical information regarding diagnosis (including treatment), payments, make appointments for health care services, having discussions with health care providers about routine tests and treatments, have access to my patient portal.

Name: ____
Address: ______________________________________
Phone Number: _____________________________
Relationship: _________________________________

Name: __________________________________
Address: ____
Phone Number: _______________________________
Relationship; _______________________________

Please list the family members or others, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY: (This person will not be given any medical information)**

- **Use the same persons as listed above**

Name: ____
Address: ____
Phone Number: _____________________________
Relationship: _________________________________

Please note that **Mental health records** are a part of a patient's overall health record, but they are considered to be a special type of protected health information (PHI). Under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Law, there's a distinction between mental health records and overall medical records, which are provided special consideration to be separate pieces of information.

The person/persons listed above may have access to my information: (circle one) and initial: __________

AIDS/HIV: Yes or No
Mental Health Information: Yes or No
Treatment for Drug or Alcohol use/abuse: Yes or No

Print Name: ___________________________________ Date: ___________________
Signature: ____
Witness signature for Verbal Consent: ______________
Print Name: ___________________________ Date: ___