

ADVANCE DIRECTIVE

I have an Advance Directive that I will provide to SVRMC for inclusion in my medical record.

I would like information about formulating an Advance Directive

I have received a copy of the "Your Right to Decide" brochure. _____(Initial)

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

To Persons involved with my care.

I hereby authorize St. Vincent Physician Practices to disclose protected information for:

Name of Patient: _____
(Last) (First) (MI)

Date of Birth: ____/____/____ **Age:** ____ **Phone:** _____ **SS#:** _____

Address: _____
(City) (State) (Zip)

My protected health information can be disclosed to family members, other relatives, a close personal friend, or other person(s) identified by me on this form for the purposes of assisting in their role as persons involved with or paying for my care.

Name of person(s) to whom Protected Health Information can be disclosed: _____

Relationship or involvement in Patient(s) care: _____

This authorization and request shall not extend to records for treatment of Mental Health, Substance Abuse, Developmental Disability, and/or HIV. Further, I understand that this authorization is not a condition of admission or treatment and I make it voluntarily.

Signature: _____ **Date:** _____

Witness: _____ **Date:** _____