BLOCK, NATION, CHASE & SMOLEN FAMILY MEDICINE

PLEASE FILL OUT THIS FORM FOR COMPLIANCE WITH THE PATIENT SELF DETERMINATION ACT, PASSED 1992 BY THE STATE OF FLORIDA.

ADVANCED DIRECTIVES

PATIENT NAME: ________________________ **DATE OF BIRTH:** _____________________

An Advanced Directive can be in the form of a living will, durable power of attorney, or health care surrogate. Is there an Advanced Directive written and executed on your behalf (or the patient's behalf, if you are responsible for the patient)? Yes _______ No _______

If yes, is this Directive in the form of:

___________ a Living Will,
___________ a Durable Power of Attorney, or
___________ a Health Care Surrogate

If you have executed an Advanced Directive in any of the above formats, have you provided this office with a copy for your medical records? Yes ________ No ________

If you would like more information regarding Advanced Directives, please ask our office staff.

____ ____________________________
Signature of Patient or Responsible Party Date

We can also incorporate a copy of any of your directives into your medical records for future reference if you provide a copy to our office.

12/2015

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