UF | UNIVERSITY of FLORIDA
Archer Family Health Care
A Service of the College of Nursing

16939 SW 134th Ave
Archer FL 32618-5413
352-495-2550 Phone
352-495-3401 Fax

Dear New Patient,

Welcome! Thank you for choosing Archer Family Health Care, a health care service of UF College of Nursing. Attached is the patient packet. We ask that you complete all pages thoroughly and bring it with you to your visit. If you take any prescribed or over-the-counter medication, please bring your bottle(s), even if empty, with you. You will need to arrive 30 minutes early to allow enough time to meet with the Financial Assistant Counselor prior to your appointment.

We are located at 16939 SW 134th Avenue in downtown Archer. If you are traveling on State Road 27/45 north bound turn left at 134th Ave; if you are traveling south bound turn right. Continue approximately 2/10th of a mile. We are located on the left side of 134th Ave.

We strive to see our patients on time and appreciate your promptness. If your wait is longer than 20 minutes, please notify the person at the front desk.
A 24 hour cancellation notice is required. However, if circumstances arise and you need to change your appointment time, please give as much notice as possible to allow someone else to be scheduled in the time reserved for you.

Please bring your photo identification and insurance information with you. We will bill your insurance company. However, you will be responsible for non-covered services, out-of-network services, deductibles, coinsurances, and/or co-payments.

If you are applying for the Reduced Payment Program, verification of your financial status and total household income is needed to determine your co-pay. If the required information is not provided, you will be charged the full fee for services rendered.

Payment is due at the time service is rendered. We accept cash or checks.

You can visit our website at http://afhc.nursing.ufl.edu to learn more about Archer Family Health Care.

Thank you for choosing our health care team.

Meet Our Team:
Denise Schentrup, DNP, ARNP, Ashley Kairalla MSN, ARNP, Suzy Roche, MSN, ARNP
Anna Schwait, MSN, ARNP, Sheri Mangueria MSN, RN
Consulting Physician Shenary J. Cotter, MD
Practice Manager Joan Newell-Walker, CMM, CPM

Clinical Support Staff
Chikako Alvarado, LPN
LaTacha Ford, LPN

Administrative Staff
Phyllis Stephens, Financial Assistance Counselor
Dawn Alexander, Financial Assistance Counselor

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Archer, FL 32618
352-495-2550 Tel; 352-495-3401 Fax

PATIENT INFORMATION

TODAY'S DATE: _____

PATIENT NAME: TITLE: ____ **FIRST** _____ **MIDDLE**_____ **LAST**_____

PREFERRED NAME/NICK NAME: _____ **BIRTH DATE:** _____

ADDRESS: _____ **CITY:** _____ **COUNTY:** _____

STATE: _____ **ZIP:** _____ **HOME PHONE:** _____ **WORK PHONE:** _____ ***CELL NUMBER:*** _____

SEX: ☐ MALE ☐ FEMALE **SOCIAL SECURITY #:** _____ ☐ **VETERAN**

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ OTHER

IF MARRIED, SPOUSE'S NAME: FIRST _____ **LAST** _____ **BIRTH DATE:** _____

EMAIL: _____ **BEST WAY TO CONTACT:**HOME/***CELL*** PHONE ☐ WORK PHONE ☐ MAIL ☐ ETTER

REFERRED BY: _____ **PRIMARY CARE:** _____

LANGUAGE SPOKEN: _____

RACE: ☐ AFRICAN AMERICAN/BLACK ☐ CAUCASIAN/WHITE ☐ ASIAN ☐ AMERICAN INDIAN/ALASKAN NATIVE
☐ NATIVE HAWAIIAN ☐ OTHER PACIFIC ISLANDER ☐ MORE THAN ONE RACE (CHOOSE BOTH) ☐ OTHER

ETHNICITY: ☐ HISPANIC OR LATINO ☐ NON-HISPANIC OR LATINO ☐ OTHER OR UNDETERMINED

EMPLOYMENT: ☐ EMPLOYED FULL TIME ☐ EMPLOYED PART TIME ☐ FULL TIME STUDENT ☐ PART-TIME STUDENT
☐ UNEMPLOYED ☐ RETIRED ☐ DISABLED

EMPLOYER OR SCHOOL: _____

ADDRESS: _____ **PHONE:** _____

PERSON TO CONTACT IN AN EMERGENCY: FIRST _____ **MIDDLE**_____ **LAST**_____

PHONE: _____ **RELATIONSHIP:** _____

TOTAL NUMBER OF FAMILY HOUSEHOLD MEMBERS: _____ ***INSURED OR UNINSURED***_____

HOUSEHOLD INCOME $_____ **PER** ☐ MONTH ☐ WEEK ☐ YEAR **SOURCE OF INCOME:** _____

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY NAME: _____

INSURED PARTY NAME: FIRST _____ **MIDDLE**_____ **LAST**_____

INSURED PARTY DATE OF BIRTH: _____ **INSURED ID:** _____ **OTHER INSURED ID:** _____

POLICY #_____ **GROUP #** _____ **GROUP NAME:** _____

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY NAME: _____

INSURED PARTY NAME: FIRST _____ **MIDDLE**_____ **LAST**_____

INSURED PARTY DATE OF BIRTH: _____ **INSURED ID:** _____ **OTHER INSURED ID:** _____

POLICY #_____ **GROUP #** _____ **GROUP NAME:** _____

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HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Previous or referring doctor:	**Date of last physical exam:**

HAVE YOU BEEN TO THE EMERGENCY ROOM IN THE PAST YEAR? ☐NO ☐YES FOR WHAT REASON?

PERSONAL HEALTH HISTORY

Immunizations and dates:	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Influenza

List any medical problems/testing that other doctors have diagnosed/completed

☐ Allergies (Seasonal) ☐ Abnormal pap smear ☐ ADHD ☐ Anxiety ☐ Arthritis ☐ Asthma ☐ Bipolar disorder ☐ COPD

☐ Cancer Type_____ ☐ Chicken Pox ☐ Chronic back pain ☐ Depression ☐ Diabetes ☐ Diverticulitis ☐ Fibromyalgia

☐ GERD ☐ Hearing problems ☐ Heart Disease ☐ Hepatitis ☐ Herpes ☐ High blood pressure ☐ High Cholesterol ☐ Migraines

☐ Miscarriages ☐ Seizures ☐ Stroke ☐ Thyroid problems ☐ Tuberculosis ☐ Vision problems ☐ Other_____

Surgeries

Year	Reason	Hospital

Other Hospitalizations

Year	Reason	Hospital

The Foundation for The Gator Nation
An Equal Opportunity Institution

Name:	DOB:

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength/frequency	Name of Drug	Strength/frequency
1.		9.	
2.		10.	
3.		11.	
4.		12.	
5.		13.	
6.		14.	
7.		15.	
8.		16.	

Allergies to medications (name the drug and reaction you had)

Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

Alcohol	Do you drink alcohol?			☐ Yes	☐ No
	If yes, what kind?				
	How many drinks per week?				
Tobacco	Do you use tobacco?			☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit			
Drugs	Do you currently use recreational or street drugs?			☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?			☐ Yes	☐ No
Safety	Have you now, or in the past, felt physically, emotionally or verbally abused or been hit, kicked, punched or slapped?			☐ Yes	☐ No
Sex	Are you sexually active?			☐ Yes	☐ No
	If yes, gender of partner?	☐ Male		☐ Female	☐ Both
	Is there any chance you may be pregnant?			☐ Yes	☐ No

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

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CONSENT AND AUTHORIZATION

MRN: _____ PATIENT NAME: _____ VISIT DATE: _____

SECTION A: NOTICE OF LIMITED LIABILITY

I, ON BEHALF OF MY SELF, MY CHILD, AND/OR MY WARD, HEREBY ACKNOWLEDGE I HAVE BEEN INFORMED THAT: Health care and treatment that I/we receive at Archer Family Health Care will be provided by University of Florida employees and/or agents, including but not limited to nurse practitioners, nurse-midwives, nurses and students, clinical pharmacists, and physicians, ("health care providers"). I understand these health care providers are under the exclusive supervision and control of the University of Florida Board of Trustees and liability for their acts or omissions is limited to $100,000 per claim or judgment by any one person and to $200,000 for all claims or judgments arising out of the same incident or occurrence (see Florida Statutes 768.28).
I further acknowledge that University of Florida health care providers are neither the employees nor agents of Shands Teaching Hospital and Clinics, Inc.

Patient/Guardian _____ Date _____ Witness _____

SECTION B: TREATMENT AUTHORIZATION, ASSIGNMENTS OF PROCEEDS, AUTHORIZATION TO RELEASE INFORMATION AND GUARANTOR AGREEMENT

I. Authorization for Routine Diagnostic Procedures and Medical Treatment – I hereby consent to such diagnostic procedures, hospital care, and medical treatment which in the judgment of my health care provider may be considered necessary or advisable while a patient at Archer Family Health Care. I recognize that Archer Family Health Care providers are employees of a health care teaching and research institution and that my treatment and care will be observed and in some instances aided by students under appropriate supervision. I consent to Archer Family Health Care taking photographs of me in the course of and related to my treatment and to their use of such photographs and my medical data for educational purposes. I hereby authorize Archer Family Health Care to retain, preserve and use for scientific, educational or research purposes, or dispose of as they might deem fit, any specimens or tissues taken from my body during hospital or clinic visits.

II. Assignment of Benefits – I hereby assign to Archer Family Health Care payment from all third party payors* with whom I have coverage or from whom benefits are or may become payable to me, for the charges of hospital and health care services I receive for, related to, or connected with this admission or treatment (past, present, or future). I agree to be personally responsible for payment of any hospital or health care services that are not covered by my third party payors*, including, but not limited to, non-covered or out-of-network services, deductibles, co-insurances, and/or co-payments.

III. Release of Medical Information by Archer Family Health Care – By signing in the space below as Patient/Guardian, I hereby authorize Archer Family Health Care providers providing services during my outpatient clinical care, to release information from and/or copies of my medical records (including information relating to psychiatric and/or psychological care, alcohol and/or substance abuse, and HIV tests), and other information as may be required for my medical care and to secure payment for charges incurred by me or on my behalf, to: any University of Florida facility or affiliated provider, the Tumor Registry, my health care provider, referring provider, the Guarantor on my accounts, insurance companies for which I have assigned benefits for my treatment and care, or to any sponsors that Archer Family Health Care may later obtain to contribute payment for my treatment and care. I also authorize release of any information to any and all regulatory and/or accrediting organizations as necessary to maintain licensure and accredited status. In addition, I authorize release of any information to county, state or federal public health agencies, as required by law. I further authorize the Department of Children and Family Services and/or the Social Security Administration to release any confidential case information to my application for government assistance, which is requested by Archer Family Health Care.

IV. Guarantor Agreement – By signing in the space below as Patient/Guardian or Guarantor, or as Patient's/Guardian's Spouse or Guarantor's Spouse, I hereby agree that all charges connected with the treatment, not covered by any insurance, program, sponsorship or other third party coverage I may have, are due and payable by my at the time of the visit or discontinuation of treatment. If the insurance information I have provided is not active at the time of service or if the services provided are not covered by my insurance company, I will be responsible for any balance due at the time of service. The charges I agree to pay are those listed in the current Fee Schedule, which is available for inspection upon request. I hereby acknowledge that, unless Archer Family Health Care and my insurance company or third party carrier have agreed that I will not be billed, if Archer Family Health Care has agreed to bill my insurance or other third party carrier it has agreed to do so as a courtesy and that Archer Family Health Care has a right to demand payment in full from me at any time prior to full payment from any insurance carrier. If an overdue account is referred by collections, I agree to pay the attorney's fees, court costs and/or collection agency fees associated with the collection process. I specifically waive any exemption of wages from garnishment, which might be available by law, and agree that my wages can be garnished in the event a Judgment is entered against me for collection of the outpatient clinic charges I have agreed to pay.

V. Lien on Third Party Liability Proceeds – If any admission or treatment is due to an accident or injury, Archer Family Health Care shall have a lien upon the proceeds of any cause of action, suit, claim, counterclaim, or demand accruing to me or my legal representative as a result of such accident or injury, in order to recover payment for all charges of hospital and health care services I receive for, related to, or connected with such accident or injury (past, present, or future), effective as of the date treatment was first provided. The foregoing shall be sufficient notice to me of the existence of a lien, which shall be effective whether or not it is filed in the public records. The foregoing is in addition to any lien to which Archer Family Health Care may be entitled by law.

VI. Agreement to Pay for Professional Component and Other Pathology Services – When a specimen of my blood, urine, stool, or similar materials is tested, the testing will be performed under the supervision of the pathologist who directs the laboratory. The pathologist may not perform the test or personally review its results. However, the pathologist is responsible for supervising the laboratory to assure that the results of all my tests are clinically reliable and are reported to my health care provider in a timely manner. I will receive a bill from the pathologist for these supervisory services for each test even if the pathologist did not personally perform the test or review its results. By signing this agreement, I agree to be responsible for the pathologist's bill to the extent that my insurer or managed care plan does not pay for it.

* Third party payors include, but are not limited to, coverage available from: Medicare, Medicaid, or governmental programs; health, accident, automobile, or other insurance; worker's compensation; HMO (commercial, Medicaid, Medicare); self-insured employers; and any sponsors who may contribute payment for services.

Patient/Guardian: _____

Patient's/Guardian's Spouse: _____

Insured _____ (If other than patient)

Insured _____ (If other than patient)

Guarantor _____ (If other than patient/guardian)

Guarantor's Spouse _____ (If other than patient's/guardian's spouse)

Witness _____

Date _____

COPIES OF THIS STATEMENT SHALL BE AS VALID AS THE ORIGINAL/ORIGINAL SIGNATURES ON FILE WITH ARCHER FAMILY HEALTH CARE

WHITE – PATIENT YELLOW – ARCHER FAMILY HEALTH CARE

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Patient Responsibility Policy

Proof of Income

1. Uninsured patients, who wish to be considered for care at a reduced cost, must provide proof of total household income each year. If proof of income is not provided on the first visit, the patient will be reminded by the Office Staff to bring this to the next visit. If proof is not provided at the time of the second visit future appointments will not be scheduled until such proof is submitted to the practice. As a reminder that proof of income is still needed, the Office Manager will send a letter to the patient requesting such information. If information is still not provided, urgent care will be provided for a period of 30 days and the patient will receive a letter of discharge fro the practice.

2. **Payment is Due at time Services are Rendered**
   Per the contract agreement between patients and insurance carriers, co-pays, deductible and any non-covered services are due at the time services are rendered. If a patient does not have health insurance, the quoted fee provided by the Office Staff is due at the time of service as well. We accept personal checks or cash.

3. **Payment Arrangement for Balance Due**
   If a patient wishes to establish a payment plan instead of paying in full for services rendered, the patient must request to speak with the Office Manager. The Office Manager will determine an appropriate payment plan based upon the patients income. The Patient and the Office Manager will agree upon the payment amount and date the payment is due in accordance with the payment plan or payments each month. It is the patient's responsibility to make contact with the Office Manager to discuss any unforeseen situations that might prevent timely payments.

   The Office Manager will contact patients who have past due balances by the 20th of each month as a reminder of the past due amount. If after 3 consecutive months there is no payment activity from the patient, the patient will be notified that Archer Family Health Care will provide only urgent care for a period of 30 days until the patient meets with the Office Manager to establish a new payment plan.

4. **Appointment Cancellations**
   Cancellation of an appointment or rescheduling of an appointment requires at least 24-hours notice.

5. **No Show**
   A "no show" occurs when a patient fails to cancel or reschedule an appointment with at least 24-hours notice. If a patient accumulates 3 "no shows" the patient will receive a letter of discharge from the practice, which dismisses you from the practice for a period of one year. If at the end of one year the patient desires to come back to the practice the patient will be accepted as a new patient.
   If a patient fails to cancel or reschedule two appointments with proper notice, a letter will be sent explaining how requests for future appointments will be handled.

6. **Adherence to Treatment**
   Health Care is a partnership between the Patient and Healthcare Provider. It is the Provider's responsibility to discuss options for care and to recommend preferred plan of care to each patient. It is the patients' responsibility to adhere to the agreed upon plan of care. If a patient does not adhere to the plan of care after discussion with the provider, the provider may discharge the patient from the practice.

I have read the above Patient Responsibilities and agree to abide to the terms

_____ _____

Patient or Guardians Signature Date

This is the template for Archer Family Health Care

UF | UNIVERSITY of FLORIDA

Date: _____

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COLLECTION AND USE OF SOCIAL SECURITY NUMBER

Your Social Security Number has been collected. It is imperative for the performance of this department's legal duties and responsibilities.

If you have questions about the collection and use of Social Security Numbers, please visit: http://privacy.ufl.edu/SSNPrivacy.html

COLLECTION AND USE OF SOCIAL SECURITY NUMBERS AT THE UNIVERSITY OF FLORIDA

ORGANIZATION	PURPOSE	STATUATORY AUTHORITY	MANDATED, AUTHORIZED OR BUSINESS IMPERATIVE
Academic Technologies	State contractual obligation	6C1-3.020	Business imperative
Admissions	Student record management	Sec. 119.071(5)(a)(2)(a)(II), Fla. Stat.	Authorized
Baby Gators Child Development	DOH CCFP reimbursement	Sec. 383.011, Fla. Stat.	Authorized
Bridges	Identity Management (UF ID)	6C1-2.0031	Business imperative
College of Dentistry	Tax reporting	Sec. 6109, I.R.C.	Mandated
College of Medicine	Tax reporting	Sec. 6109, I.R.C.	Mandated
College of Nursing	Tax reporting; licensure	Sec. 6109, I.R.C.	Mandated; Authorized
College of Nursing Archer Clinic	Patient registration; health insurance claims or verification	6C1-1.300	Business imperative
College of Pharmacy	Tax reporting; student applications; education certifications	Sec. 6109, I.R.C.; Rule 64B16-26.203 & 2032, F.A.C.	Mandated; Business imperative
College of Public Health & Health Professions	Tax reporting	Sec. 6109, I.R.C.	Mandated
College of Veterinary Medicine	Tax reporting	Sec. 6109, I.R.C.	Mandated
Continuing Education	Licensure; identity management; student record management	Sec. 119.071(5)(a)(2)(a)(II), Fla. Stat.	Authorized
Faculty Practice Assoc (Dental Clinics)	Tax reporting; patient registration & health insurance verification	Sec. 6109, I.R.C.; 6C1-1.300	Mandated; Business imperative
Health Science Center Contracts	Contract services & management		Business imperative
Housing and Residence Education	Florida Prepaid Housing Program Reimbursement	Section 1009.98, Fla. Stat.	Authorized
Human Resource Services	Tax reporting; benefits eligibility	Sec. 6109, I.R.C.; 6C1-1.200	Mandated; Business imperative
IFAS Extension, 4-H Programs	FDLE & Background Checks	6C1-6.013; 6C1-3.0031	Business imperative
Psychology Clinic	Patient registration; health insurance verification; SSDI benefits	Sec. 119.071(5)(a)(2)(a)(II), Fla. Stat.	Authorized
Purchasing and Disbursements	Tax reporting; contracts & purchases	26 U.S.C. 6041.; 6C1-3.020	Mandated; Business imperative
Registrar	Student record management & VA benefits	Sec. 119.071(5)(a)(2)(a)(II), Fla. Stat.	Authorized
Reitz Union	Tax reporting	Sec. 6109, I.R.C.	Mandated
Research (Sponsored Research & General Clinical Research Ctr)	Tax reporting	Sec. 6109, I.R.C.	Mandated
Research Affairs & Compliance (RAC)	Tax reporting	Sec. 6109, I.R.C.	Mandated
Speech & Hearing Clinics	Patient registration; health insurance verification	Sec. 119.071(5)(a)(2)(a)(II), Fla. Stat.	Authorized
Student Financial Affairs	Financial aid programs	PL 110-315, Sec. 483	Authorized
Student Health Care Center	Health insurance verification	Sec. 119.071(5)(a)(2)(a)(II), Fla. Stat.	Authorized
Study Abroad Services (UF International Center)	Florida Prepaid Tuition Reimbursement	Section 1009.98, Fla. Stat.	Authorized
UF Physicians (Medical Clinics)	Tax reporting; health insurance	Sec. 6109, I.R.C.; 6C1-1.300	Mandated; Business imperative
UF Proton Therapy Institute	Tax reporting; health insurance verification	Sec. 6109, I.R.C.; 6C1-1.300	Mandated; Business imperative
UF Jacksonville Healthcare (Medical Clinics)	Tax reporting; health insurance verification	Sec. 6109, I.R.C.; 6C1-1.300	Mandated; Business imperative
University Financial Services	Tax reporting; financial aid; collections	Sec. 6109, I.R.C.; 6C1-3.042; Sec. 1010.03, Fla. Stat.	Mandated; Authorized
Veterinary Medical Center	Promissory notes/credit applications	15 U.S.C. Sec. 1681 et seq.	Authorized

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2014-15 APPLICATION FOR REDUCED COPAYMENT HEALTH CARE

Based on the information you provided, it appears that you may qualify for reduced co-payment. Please fill out the following form completely and honestly. List all income from all sources including Self-employment, Contributions from friends/relatives, Social Security Benefits, Pensions, Interest, Dividends, Child Support, Veterans Benefits, Unemployment/Workers' Compensation Rail Road Retirement, Annuities/Rent, Food Stamps and any other government assistance. List all types of assets including Cash, Checking Account, Savings Account, Property/Land, Cars, Trucks, Motorcycles, Boats, Life Insurance, Trust Funds, Stocks, Bonds, CD's.

NAME: _____SOCIAL SECURITY #_____-___-_____ DATE OF BIRTH_____

**************************HOUSEHOLD MEMEBERS************************

List yourself and all other household members and your relation to them. List the total monthly income for each family member. If a member has no incomes list the reason. Indicate if a member has Medicaid or Food Stamps. All patients applying for free or reduced services should apply for Medicaid and Food Stamps. If a member does not have Medicaid or Food Stamps state the reason for denial.

Member Name	Relation to You	Date of Birth	Monthly Income and Source	Medicaid or Food Stamps

Revised 7/2014;jnw

Rights and Responsibilities for Financially Assisted Health Care

Archer Family Health Care provides medical care at reduced charges. The charges are based on income and asset information. Services will be provided at a $5.00 charge to individuals at or below the Federal Poverty guidelines and reduced fees will apply up to 200% of the Poverty guideline.

I am applying for reduced co-payment for my medical care to be received at Archer Family Health Care. I understand that Reduced co-payment services do not apply to outside laboratories or referrals for services performed outside of Archer Family Health Care. I understand that I have to give true and complete information on this form under penalty of perjury and can be prosecuted if I lie or hide information.

I agree that Archer Family Health Care and University of Florida, College of Nursing may verify the information I give on this form. I agree that they may contact my present or past employers if it relates to my eligibility. I agree that they may get information that affects my eligibility from any records or sources including information exchanges with other agencies.

I agree to notify Archer Family Health Care of any change in my situation immediately.

I have read and kept a copy of my Rights and Responsibilities. I declare the information provided on the other side of this form is true to the best of my knowledge. If false information is reported on this application you will be discharged from Archer Family Health Care.

_____ _____

Signature of Applicant/Guardian Date

_____ _____

Witness Date

Revised 7/2014;jnw

UF UNIVERSITY of FLORIDA

UFHealth
UNIVERSITY OF FLORIDA HEALTH

ACKNOWLEDGEMENT of Receipt

MRN: _____ PATIENT NAME: _____ VISIT DATE: _____

I have been provided a copy of the Joint Notice of Privacy Practices for the University of Florida and UF Health Shands. I understand that I may ask questions about this Notice at any time.

Patient Signature: _____ Date: _____

If not signed by the patient, please indicate relationship:

Legal Representative Signature: _____ Date: _____

Relationship to Patient: _____

_____

***For Office Use Only*:**

Signed form received by: _____
Print Name

_____
Print Facility Name

☐ Declined to Sign Acknowledgment

Efforts to obtain signature: _____

_____

Reasons for refusal:

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JOINT NOTICE OF PRIVACY PRACTICES AND NOTICE OF ORGANIZED HEALTH CARE ARRANGEMENT

Effective Date: September 23, 2013

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this Notice, please contact either the Privacy Office for UF Health Shands or the Privacy Office for the University of Florida at the contact information listed below:

UF Health Shands Privacy Office 1-866-682-2372

University of Florida Privacy Office 1-866-876-4472

OUR LEGAL DUTY TO PROTECT HEALTH INFORMATION ABOUT YOU

We understand your health information is personal and we are committed to protecting it. We create a record of the care and services you receive at UF Health Shands or the University of Florida Health Science Center (UFHSC) to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated by UF Health Shands and/or the UFHSC, whether made by hospital personnel, University of Florida faculty, staff, students, or your personal doctor. This Notice describes how we may use and disclose your health information, and provides examples where necessary. This Notice also describes your rights regarding your health information.

We are required by law to maintain the privacy of health information, to provide individuals with notice of our legal duties and privacy practices with respect to health information, and to abide by the terms of the notice currently in effect.

CHANGES TO THIS NOTICE

We reserve the right to change our privacy practices and this notice at any time. We reserve the right to make the revised notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice at all our facilities.

NOTICE OF ORGANIZED HEALTH CARE ARRANGEMENT

UF Health Shands, which for the purposes of this notice includes Shands Teaching Hospital and Clinics, Inc. and Shands Jacksonville Medical Center, Inc., and the UFHSC, together with the UFHSC clinics* and other affiliated health care providers have agreed as permitted by law, to share your health information among themselves for purposes of treatment, payment or health care operations. This arrangement enables us to better address your health care needs in the integrated setting found within UF Health Shands and the University of Florida health care providers.

The organizations participating in the Joint Notice are participating only for the purposes of providing this Joint Notice and sharing medical information as permitted by applicable law. These organizations are not in any way providing health care services mutually or on each other's behalf. UF Health Shands and the University of Florida are separate health care providers and each is individually responsible for its own activities, including compliance with privacy laws, and all heath care services it provides.

CONSISTENT WITH STATE AND FEDERAL LAW, WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION WITHOUT YOUR WRITTEN PERMISSION IN THE FOLLOWING CIRCUMSTANCES:

We may use and disclose your health information to **provide medical treatment to you and to coordinate or manage your health care and related services**. This may include communicating with other health care providers regarding your treatment and coordinating and managing your health care with others. For example: we may use and disclose your health information when you need lab work or an x-ray. Also, we may use and disclose your health information when referring you to another health care provider or to recommend treatment alternatives to you.

We may use and disclose your health information to **bill and receive payment for services rendered**. For example: A bill may be sent to you or your insurance company. The items on, or accompanying, the

bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used so that your health plan will pay the medical bill. We may also tell your health plan about a treatment you are expected to receive in order to obtain prior approval or to determine if your health plan will pay for that treatment.

We may use and disclose your health information for **health care operations**. We will use your health information for regular operations of the hospital and clinics to provide patients with quality care. For example: Members of the medical staff, the risk management team or the quality improvement team, including Patient Safety Organizations (PSOs), may use information in your health record to assess the care you receive and the outcomes of your treatment. We may also disclose information to doctors, nurses, technicians, medical students and other UFHSC personnel for review and teaching purposes.

We may also use and disclose your health information:

- When necessary to **prevent a serious threat to your health and safety** or the health and safety of the public or another person.
- To **organizations that facilitate donation and transplantation** of tissues and/or organs.
- To **authorized officials** when **required by federal, state, or local law.**
- In response to a **subpoena, court, or other administrative order**.
- As required by law, for **public health activities.** For example: preventing or controlling disease, reporting births and deaths, and reporting abuse and neglect.
- For authorized **Worker's Compensation activities.**
- To **health oversight agencies.** For example: agencies that enforce compliance with licensure or accreditation requirements.
- To **coroners, medical examiners, or funeral directors** to carry out their duties.
- As required by **military command authorities,** if you are a member of the armed forces.
- To our **business associates** to carry out treatment, payment, or health care operations on our behalf. For example: we may disclose health information about you to a company who bills insurance companies for our services.
- For **research or to collect information in databases to be used later for research**. All research projects are reviewed and approved by an independent review board to protect the privacy of your health information.
- To a **correctional institution having lawful custody of you** as necessary for your health and the safety of others.

We may also use and disclose your information for **fundraising activities** to raise money for UF Health Shands or UFHSC and their operations. If you do not want to be contacted for fundraising efforts, you must notify either the UF Health Shands Privacy Office or the University of Florida Privacy Office.

SPECIAL CIRCUMSTANCES

Alcohol, Drug Abuse, Psychotherapy Notes, and Psychiatric Treatment Information may have special privacy protections. We will not disclose any health information identifying an individual as a patient or provide information relating to the patient's substance abuse or psychiatric treatment unless:

1. You or your personal representative consents in writing;
2. A court order requires disclosure;
3. Medical personnel need information to treat you in a medical emergency;
4. Qualified personnel use the information for research or operations activities;
5. It is necessary to report a crime or a threat to commit a crime; or
6. To report abuse or neglect as required by law.

YOU MAY REFUSE TO PERMIT CERTAIN USES AND DISCLOSURES OF YOUR HEALTH INFORMATION

Unless you object, we may use or disclose your health information in the following circumstances:

- **Hospital Directories**. We may share your name, room number, and condition in our patient listing with clergy and with people who ask for you by name. We also may share your religious affiliation with clergy.
- **Individuals Involved in Your Care or Payment for Your Care.** We may use or disclose information to a family member, legal representative, or other persons involved with or responsible for your care or the payment of your care.
- **Emergency Circumstances and Disaster Relief**. We may disclose information about you to an agency assisting in a disaster relief effort so that your family can be notified of your location and general condition. Even if you object, we may still share the health information about you, if necessary for emergency circumstances.

USES AND DISCLOSURES OF HEALTH INFORMATION THAT REQUIRE YOUR WRITTEN PERMISSION

Other uses and disclosures of health information not covered by this notice or applicable law will be made only with your written permission. If you provide permission to use or disclose health information, you may revoke that permission at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your revocation. We are unable to take back any disclosures already made with your permission.

We will not use or disclose your protected health information for marketing purposes, nor will we sell your protected health information without your written permission.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the following rights regarding health information we maintain about you:

- **Right to See and Obtain Copies of your Health Information**

  You have the right to see and obtain copies of health information used to make decisions about your care. Usually, this includes medical and billing records, and excludes psychotherapy notes.

  To view and copy your health information, you must submit your written request on the appropriate form to Health Information Management or the Clinic Manager. We may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to see and obtain copies of your health information in certain very limited circumstances. You have the right to appeal the denial.

- **Right to Amend**

  If you think that your health and billing information is incorrect or incomplete, you may ask us to correct it. We may deny your request if:

  1) The information was not created by us;
  2) The information is not part of the records used to make decisions about your care;
  3) We believe the information is correct and complete; or
  4) You do not have the right to review parts of the medical record under certain circumstances.

  We will tell you in writing the reasons for the denial and describe your rights to give us a written statement disagreeing with the denial.

  If we accept your request to amend the information, we will make reasonable efforts to inform others of the amendment, as needed, including persons you name who have received information about you and who need the amendment. Your request must be in writing and include an explanation of your reason(s) for the amendment. The request must be submitted on the proper

form to the Health Information Management or Clinic Manager where you received treatment.

- **Right to an Accounting of Disclosures**

  You have the right to request an Accounting of Disclosures. This Accounting of Disclosures report does not include disclosures made for your treatment, payment, or health care operations. It also does not include disclosures made to or requested by you, or that you authorized.

  You must submit your request for a report in writing to the Health Information Management or the Clinic Manager where you received care. Your request must state a time period, which is limited to the previous six years from the date of the request. The first request for an accounting of disclosures will be provided free of charge. We may charge you for additional report requests made within a 12 month period.

- **Right to Request Restrictions**

  You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. If we agree with your request, we will comply unless the information is needed to provide emergency treatment, is required by law, or otherwise required to be disclosed as listed in this notice.

  You must make your request for restrictions in writing to either the UF Health Shands Privacy Office or the UF Privacy Office. Your request must include what information you want to limit and how you want the limits to apply.

  You have the right to restrict disclosures of health information made to a health plan when the items or services were paid in full prior to being rendered. Certain limitations apply.

- **Right to Choose How We Communicate With You**

  You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example: you can ask that we only contact you at work or by mail. You must make your request for alternate communications in writing to the Admissions supervisor at UF Health Shands, or to the UF Clinic Managers or supervisors. We will not ask you the reason for your request and will accommodate reasonable requests.

- **Right to a Paper Copy of This Notice**

  You have the right to receive a copy of this notice from UF Health Shands or any UF clinic. You may obtain an electronic copy of this notice from our websites at: https://ufhealth.org/patient-care or www.privacy.health.ufl.edu.

- **Right to Breach Notification**

  You have the right to and will receive notification in the event of a breach of your unsecured protected health information, unless such notification is exempted by law.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us. You will not be penalized or denied services for filing a complaint. To file a privacy complaint with UF Health Shands, please contact the Privacy Office, at, P.O. Box 103175, Gainesville, FL 32610-3175, or call 1-866- 682-2372. To file a privacy complaint with the UFHSC or UF Clinics, please contact the UF Privacy Office at P.O. Box 113210, Gainesville, FL 32611 or call 1-866-876-4472. All complaints must be submitted in writing on the appropriate form that is available on our website: www.privacy.health.ufl.edu. To file a complaint with the Secretary of the Department of Health and Human Services, visit the Office for Civil Rights website at www.hhs.gov/ocr.

*The University of Florida clinics and physicians' offices; the Florida Clinical Practice Association; the University of Florida Jacksonville Physicians, Inc., the University of Florida Jacksonville Healthcare, Inc.; the University of Florida Colleges of Medicine, Nursing, Health Professions, Dentistry and Pharmacy; the University Proton Therapy Institute; and other affiliated health care providers, including all employees, volunteers, staff and other University of Florida health services staff.

UF | UNIVERSITY of FLORIDA

AUTHORIZATION to Use or Disclose Protected Health Information (PHI)

Patient's Name	Date of Birth	Verification of Identity (Driver's License, ID Card, Passport, etc.)
Patient's Address	Medical Record Number	

** Complete the following only if the person authorizing the use or disclosure is not the patient:

Representative's Name	Relationship to Patient	Legal Authority
Representative's Address	Verification of Identity	Verification of Authority

By signing this form, I authorize the following:

Disclosure of the patient's PHI **from**:		Disclosure of the patient's PHI **to**:	
Person, class of persons, or organization		***Person, class of persons, or organization*** ***Archer Family Health Care***	
Address		***Address*** ***16939 SW 134th Ave***	
		Archer FL 32618-5413	
Attn:	*Phone* *Fax*	***Phone*** ***352-495-2550***	***Fax*** ***352-495-3401***

The following protected health information may be disclosed:

I further authorize the disclosure of the following information which may be included in the protected health information listed above. (*Check all that are approved.*)

☐ Mental Health	☐ Substance Abuse	☐ HIV/AIDS	☐ Records created by non-UF/Shands providers

The purpose of the disclosure is:

I understand that, by federal law, the University of Florida may not use or disclose protected health information without authorization except as provided in the University's Notice of Privacy Practices. By signing this Authorization, I am giving permission for the uses and disclosures of the described protected health information. I hereby release the University of Florida and its employees from any and all liability that may arise from the release of information as I have directed.

I understand that I have the right to revoke this Authorization at any time, if I do so in writing, and address it to the person or institution named above. I understand that the revocation will not apply to any actions already taken as a result of this authorization.

I understand that I may refuse to sign this Authorization, and that the institutions or individuals named above cannot deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign.

I understand that information disclosed pursuant to this Authorization may no longer be protected by the federal medical privacy law and could be disclosed by the person or agency that receives it.

I understand that I may be charged a fee of up to $1.00 per page (plus applicable tax and handling) for every page copied and that this fee is within the limits allowed by Florida law.

This authorization expires automatically one (1) year from the date signed, if no other date or event is specified.	*Expiration Date or Event*
This authorization may be used to disclose protected health information of the same type described above, which may be created in the future, until the expiration date.	☐ YES ☐ NO
I have read and understand the information in this authorization form.	
Signature of Patient or Legal Representative:	*Date*

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Health Care Advance Directives

The Patient's Right to Decide

Every competent adult has the right to make decisions concerning his or her own health, including the right to choose or refuse medical treatment.

When a person becomes unable to make decisions due to a physical or mental change, such as being in a coma or developing dementia (like Alzheimer's disease), they are considered incapacitated. To make sure that an incapacitated person's decisions about health care will still be respected, the Florida legislature enacted legislation pertaining to health care advance directives (Chapter 765, Florida Statutes). The law recognizes the right of a competent adult to make an advance directive instructing his or her physician to provide, withhold, or withdraw life-prolonging procedures; to designate another individual to make treatment decisions if the person becomes unable to make his or her own decisions; and/or to indicate the desire to make an anatomical donation after death.

By law hospitals, nursing homes, home health agencies, hospices, and health maintenance organizations (HMOs) are required to provide their patients with written information, such as this pamphlet, concerning health care advance directives. The state rules that require this include 58A-2.0232, 59A-3.254, 59A-4.106, 59A-8.0245, and 59A-12.013, Florida Administrative Code.

Questions About Health Care Advance Directives

What is an advance directive?
It is a written or oral statement about how you want medical decisions made should you not be able to make them yourself and/or it can express your wish to make an anatomical donation after death. Some people make advance directives when they are diagnosed with a life-threatening illness. Others put their wishes into writing while they are healthy, often as part of their estate planning.

Three types of advance directives are:

- A Living Will
- A Health Care Surrogate Designation
- An Anatomical Donation

You might choose to complete one, two, or all three of these forms. This pamphlet provides information to help you decide what will best serve your needs.

What is a living will?
It is a written or oral statement of the kind of medical care you want or do not want if you become unable to make your own decisions. It is called a living will because it takes effect while you are still living. You may wish to speak to your health care provider or attorney to be certain you have completed the living will in a way that your wishes will be understood.

What is a health care surrogate designation?
It is a document naming another person as your representative to make medical decisions for you if you are unable to make them yourself. You can include instructions about any treatment you want or do not want, similar to a living will. You can also designate an alternate surrogate.

Which is best?
Depending on your individual needs you may wish to complete any one or a combination of the three types of advance directives.

What is an anatomical donation?
It is a document that indicates your wish to donate, at death, all or part of your body. This can be an organ and tissue donation to persons in need, or donation of your body for training of health care workers. You can indicate your choice to be an organ donor by designating it on your driver's license or state identification card (at your nearest driver's license office), signing a uniform donor form (seen elsewhere in this pamphlet), or expressing your wish in a living will.

Am I required to have an advance directive under Florida law?
No, there is no legal requirement to complete an advance directive. However, if you have not made an advance directive, decisions about your health care or an anatomical donation may be made for you by a court-appointed guardian, your wife or husband, your adult child, your parent, your adult sibling, an adult relative, or a close friend.

The person making decisions for you may or may not be aware of your wishes. When you make an advance directive, and discuss it with the significant people in your life, it will better assure that your wishes will be carried out the way you want.

Must an attorney prepare the advance directive?
No, the procedures are simple and do not require an attorney, though you may choose to consult one. However, an advance directive, whether it is a written document or an oral statement, needs to be witnessed by two individuals. At least one of the witnesses cannot be a spouse or a blood relative.

Where can I find advance directive forms?
Florida law provides a sample of each of the following forms: a living will, a health care surrogate, and an anatomical donation. Elsewhere in this pamphlet we have included sample forms as well as resources where you can find more information and other types of advance directive forms.

Can I change my mind after I write an advance directive?
Yes, you may change or cancel an advance directive at any time. Any changes should be written, signed and dated. However, you can also change an advance directive by oral statement; physical destruction of the advance directive; or by writing a new advance directive.

If your driver's license or state identification card indicates you are an organ donor, but you no longer want this designation, contact the nearest driver's license office to cancel the donor designation and a new license or card will be issued to you.

What if I have filled out an advance directive in another state and need treatment in Florida?
An advance directive completed in another state, as described in that state's law, can be honored in Florida.

What should I do with my advance directive if I choose to have one?

- If you designate a health care surrogate and an alternate surrogate be sure to ask them if they agree to take this responsibility, discuss how you would like matters handled, and give them a copy of the document.
- Make sure that your health care provider, attorney, and the significant persons in your life know that you have an advance directive and where it is located. You also may want to give them a copy.
- Set up a file where you can keep a copy of your advance directive (and other important paperwork). Some people keep original papers in a bank safety deposit box. If you do, you may want to keep copies at your house or information concerning the location of your safety deposit box.
- Keep a card or note in your purse or wallet that states that you have an advance directive and where it is located.
- If you change your advance directive, make sure your health care provider, attorney and the significant persons in your life have the latest copy.

If you have questions about your advance directive you may want to discuss these with your health care provider, attorney, or the significant persons in your life.

More Information On Health Care Advance Directives

Before making a decision about advance directives you might want to consider additional options and other sources of information, including the following:

- As an alternative to a health care surrogate, or in addition to, you might want to designate a durable power of attorney. Through a written document you can name another person to act on your behalf. It is similar to a health care surrogate, but the person can be designated to perform a variety of activities (financial, legal, medical, etc.). You can consult an attorney for further information or read Chapter 709, Florida Statutes.

  If you choose someone as your durable power of attorney be sure to ask the person if he or she will agree to take this responsibility, discuss how you would like matters handled, and give the person a copy of the document.

- If you are terminally ill (or if you have a loved one who is in a persistent vegetative state) you may want to consider having a pre-hospital Do Not Resuscitate Order (DNRO). A DNRO identifies people who do not wish to be resuscitated from respiratory or cardiac arrest. The pre-hospital DNRO is a specific yellow form available from the Florida Department of Health (DOH). Your attorney, health care provider, or an ambulance service may also have copies available for your use. You, or your legal representative, and your physician sign the DNRO form. More information is available on the DOH website, www.doh.state.fl.us or www.MyFlorida.com (type DNRO in these website search engines) or call (850) 245-4440.

  When you are admitted to a hospital the pre-hospital DNRO may be used during your hospital stay or the hospital may have its own form and procedure for documenting a Do Not Resuscitate Order.

- If a person chooses to donate, after death, his or her body for medical training and research the donation will be coordinated by the Anatomical Board of the State of Florida. You, or your survivors, must arrange with a local funeral home, and pay, for a preliminary embalming and transportation of the body to the Anatomical Board located in Gainesville, Florida. After being used for medical education or research, the body will ordinarily be cremated. The cremains will be returned to the loved ones, if requested at the time of donation, or the Anatomical Board will spread

the cremains over the Gulf of Mexico. For further information contact the Anatomical Board of the State of Florida at (800) 628-2594 or www.med.ufl.edu/anatbd.

- If you would like to learn more on organ and tissue donation, please visit the Joshua Abbott Organ and Tissue Donor Registry at www.DonateLifeFlorida.org where you can become organ, tissue and eye donors online. If you have further questions about organ and tissue donation you may want to talk to your health care provider.

- Various organizations also make advance directive forms available. One such document is "Five Wishes" that includes a living will and a health care surrogate designation. "Five Wishes" gives you the opportunity to specify if you want tube feeding, assistance with breathing, pain medication, and other details that might bring you comfort such as what kind of music you might like to hear, among other things. You can find out more at:

  Aging with Dignity
  www.AgingWithDignity.org
  (888) 594-7437

  Other resources include:

  American Association of Retired Persons (AARP)
  www.aarp.org
  (Type "advance directives" in the website's search engine)

  Your local hospital, nursing home, hospice, home health agency, and your attorney or health care provider may be able to assist you with forms or further information.

  Brochure: End of Life Issues
  www.FloridaHealthFinder.gov
  (888) 419-3456

Living Will

Declaration made this _____ day of _____, 2____, I, _____, willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare that, if at any time I am mentally or physically incapacitated and

_____(initial) I have a terminal condition,
or _____(initial) I have an end-stage condition,
or _____(initial) I am in a persistent vegetative state,

and if my attending or treating physician and another consulting physician have determined that there is no reasonable medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

I do ___, I do not ___ desire that nutrition and hydration (food and water) be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying.

It is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal.

In the event I have been determined to be unable to provide express and informed consent regarding the withholding, withdrawal, or continuation of life-prolonging procedures, I wish to designate, as my surrogate to carry out the provisions of this declaration:

Name _____
Street Address _____
City _____ State _____ Phone _____

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

Additional Instructions (optional): _____
_____
_____
_____
_____

(Signed) _____

Witness _____
Street Address _____
City _____ State _____
Phone _____

Witness _____
Street Address _____
City _____ State _____
Phone _____

At least one witness must not be a husband or wife or a blood relative of the principal.

Definitions for terms on the Living Will form:

"End-stage condition" means an irreversible condition that is caused by injury, disease, or illness which has resulted in progressively severe and permanent deterioration, and which, to a reasonable degree of medical probability, treatment of the condition would be ineffective.

"Persistent vegetative state" means a permanent and irreversible condition of unconsciousness in which there is: The absence of voluntary action or cognitive behavior of any kind and an inability to communicate or interact purposefully with the environment.

"Terminal condition" means a condition caused by injury, disease, or illness from which there is no reasonable medical probability of recovery and which, without treatment, can be expected to cause death.

These definitions come from section 765.101 of the Florida Statues. The Statutes can be found in your local library or online at www.leg.state.fl.us.

Designation of Health Care Surrogate

Name: _____

In the event that I have been determined to be incapacitated to provide informed consent for medical treatment and surgical and diagnostic procedures, I wish to designate as my surrogate for health care decisions:

Name _____
Street Address _____
City _____ State _____ Phone _____
Phone: _____

If my surrogate is unwilling or unable to perform his or her duties, I wish to designate as my alternate surrogate:

Name _____
Street Address _____
City _____ State _____ Phone _____

I fully understand that this designation will permit my designee to make health care decisions and to provide, withhold, or withdraw consent on my behalf; or apply for public benefits to defray the cost of health care; and to authorize my admission to or transfer from a health care facility.
Additional instructions (optional):

_____
_____
_____
_____

I further affirm that this designation is not being made as a condition of treatment or admission to a health care facility. I will notify and send a copy of this document to the following persons other than my surrogate, so they may know who my surrogate is.

Name _____
Name _____

Signed _____

Date _____

Witnesses 1. _____

2. _____

At least one witness must not be a husband or wife or a blood relative of the principal.

Uniform Donor Form

The undersigned hereby makes this anatomical gift, if medically acceptable, to take effect on death. The words and marks below indicate my desires:

I give:

(a) _____ any needed organs or parts

(b) _____ only the following organs or parts for the purpose of transplantation, therapy, medical research, or education:

_____

_____

_____

(c) _____ my body for anatomical study if needed. Limitations or special wishes, if any:

_____

_____

_____

Signed by the donor and the following witnesses in the presence of each other:

Donor's Signature _____ Donor's Date of Birth _____

Date Signed _____ City and State _____

Witness _____
Street Address _____
City _____ State _____

Witness _____
Street Address _____
City _____ State _____

You can use this form to indicate your choice to be an organ donor. Or you can designate it on your driver's license or state identification card (at your nearest driver's license office).

The card below may be used as a convenient method to inform others of your health care advance directives. Complete the card and cut it out. Place in your wallet or purse. You can also make copies and place another one on your refrigerator, in your car glove compartment, or other easy to find place.

Health Care Advance Directives

I, _____
have created the following Advance Directives:

___ Living Will

___ Health Care Surrogate Designation

___ Anatomical Donation

___ Other (specify) _____

---------- FOLD ----------

Contact:
Name _____

Address _____
_____
_____

Phone _____

Signature _____ Date _____

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