

Please **take time** to provide the following information for our files. This information is treated with strict confidentiality and will help us obtain a comprehensive assessment of your health care needs. **Please address every section.**

PATIENT NAME	BIRTH DATE	TODAY'S DATE
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MEDICAL HISTORY UPDATES

Since your last visit

Please list any Surgeries-Procedures-Hospitalizations, ER visits or Urgent Care Visits

☐ **NONE**

Any New Allergies:

☐ **NONE**

Reaction:

Have you seen any specialist since your last visit? ☐ No ☐ Yes, if yes please list below.

Location seen at:

Location seen at:

Location seen at:

IMMUNIZATIONS & PREVENTIVE SERVICES Please list any vaccinations or testing that you have had since your last visit and PROVIDE DATE and SERVICE LOCATION (Pharmacy/Hospital/physician order)

☐ **NONE** ☐ Flu vaccine ☐ Tetanus ☐ Pneumococcal ☐ PAP smear ☐ Mammogram ☐ Colonoscopy

FAMILY HISTORY

Has anything changed with the health of your biological relatives since your last visit?

Please note which relatives are affected, if extended family, such as aunt/cousin/grandparent, please note whether on maternal (mother's) or paternal (father's) side.

Include behavioral health. Examples are: stress, schizophrenia, alcohol, prescription drug abuse, illegal drug use, maternal depression. etc.

☐ **NONE**

MEDICAL SUPPLY TEAM

Please list any companies involved in your care including oxygen, wheelchair services, durable medical equipment and suppliers.

☐ **NONE**

SOCIAL / PERSONAL HISTORY UPDATE

Please complete the following information about yourself.

Current Occupation: _____

Current employment status: ☐ Full-time ☐ Part-time ☐ Unemployed ☐ Student ☐ Stay-at-home ☐ Retired ☐ Disabled

Have you had a change in marital status: Y / N If yes please update: _____

Personal habits: (check all that apply) ☐ Never used nicotine

☐ Currently nicotine use: Type: ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Smokeless tobacco ☐ e-Cigarettes

Amount / day: _____ Years: _____

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☐ Former nicotine use: Type/ amount / day: _____ Years: _____ Quit Date: _____

☐ Exposed to second-hand smoke/nicotine Amount / day: _____ Years: _____

Last dental appointment _____ Any oral health issues? Y / N If yes _____

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several Days	More than half the days	Nearly every day
Feeling nervous, anxious or on edge				
Not being able to stop or control worrying				

Do you drink alcohol or use substances? Y / N If Y, please fill in below

- Have you ever felt you needed to Cut down on your drinking or substances use? Y / N
- Have people Annoyed you by criticizing your drinking or substances use? Y / N
- Have you ever felt Guilty about drinking or substances use? Y / N
- Have you ever felt you needed a drink or used substances first thing in the morning (Eye-opener) to steady your nerves or to get rid of a hangover? Y / N
- Recent Use: please check any substances used and note number of days/month used and usual amount:

☐ NONE ☐ Alcohol ☐ Amphetamines ☐ Benzodiazepines ☐ Cocaine/Crack ☐ Marijuana ☐ Methadone ☐ Heroin

☐ Opiates (Lortab, OxyContin) ☐ Other substances: ☐ _____

Do you exercise regularly? Y / N If Yes, type and frequency: _____

Do you eat 5 or more servings of fruit and vegetables most days? Y / N

Do you have any unsecured guns in the home? Y / N

Would you like to be screened for HIV or sexually transmitted diseases? Y / N

If born between 1945-1965, would you like to be screened for Hepatitis C? Y / N

Please describe your comfort level in understanding concepts and care requirements related to managing your health ☐ no concerns ☐ occasional difficulty, with guidance/direction feel comfortable ☐ frequent difficulty, require extra assistance

Living Situation/Circumstances:

Do you live alone? Y / N If No, with whom do you live? _____

Do you have a caregiver? Y / N If Yes, whom: _____

Are you a caregiver for an adult? Y / N If Yes, for whom: _____

Do you have any pets? Y / N If Yes, type/how many: _____

Do you have a good support network of family/friends? Y / N If No, please explain: _____

Do you have concerns about meeting basic needs for shelter, food, and clothing? Y / N If Yes, would you like information on resources that may be of assistance to you? Y / N

Do you have trouble affording the care or prescriptions prescribed? Y / N

Do you have any communication needs due to hearing, seeing, memory and mental conditions or difficulty reading? Y / N If Yes, please explain: _____

Do you have any beliefs or practices, which affect decision-making, coping, commitment to treatment, use of complementary health practices and general wellbeing? Y / N If Yes, please explain: _____

Do you have a health care proxy? Y / N / Not Sure If Yes, please share a copy for your records.

Do you have advanced care directives? Y / N / Not Sure If Yes, please ensure this practice has a copy for your records. Would you like to discuss Advance Directives or a Healthcare Proxy at your visit? Y / N

REVIEW OF SYSTEMS

PATIENT NAME	BIRTH DATE	TODAY'S DATE
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GENERAL HEALTH			
Is your general health good? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Do you have or have you <u>recently</u> had:			
Gain or loss of weight without trying?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Drenching sweats at night?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fever or chills?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low energy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Changes in vision?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Contact or glasses	<input type="checkbox"/> Yes <input type="checkbox"/> No
Itchy or dry eyes?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Difficulty hearing?	<input type="checkbox"/> Yes <input type="checkbox"/> No	ringing in your ears?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Runny nose?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Congestion in your nose or sinus pain/pressure?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Change in your voice or hoarseness?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dentures?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chest pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainted or felt as though you were about to faint?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Feeling your heart skipping beats or racing?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty exercising due to shortness of breath/fatigue?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pain in your buttocks (rear-end) or legs when walking?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of breath that awakens you at night?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Swollen legs or ankles?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of breath lying flat in bed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Wheezing (high pitched breathing noises)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Trouble staying awake in the daytime?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of breath?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Decreased appetite?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent diarrhea?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Difficulty swallowing?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent constipation (hard, painful bowel movement/poop)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pain in your abdomen (belly)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Black, tarry, or bloody stools (poops)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Frequent indigestion/heartburn?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Change in color or size of stool?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Frequent nausea or vomiting?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Leaking of stool?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Burning when you urinate (pee)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weakness of urinary stream?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Leaking of urine?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Waking up more than twice per night to urinate?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Frequent urination?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Urgent need to urinate immediately?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood in your urine?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
WOMEN ONLY			
Irregular, heavy, or overly painful menstrual periods?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If you are postmenopausal (completed "change in life"), any vaginal bleeding since menopause?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pain with sex?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
MEN ONLY			
Do you have difficulty achieving or maintaining an erection?	<input type="checkbox"/> Yes <input type="checkbox"/> No		

PATIENT NAME	BIRTH DATE
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<i>Do you have or have you <u>recently</u> had:</i>	
Unexplained muscle aches? <input type="checkbox"/> Yes <input type="checkbox"/> No	Joint stiffness upon awakening or sitting for prolonged period of time? <input type="checkbox"/> Yes <input type="checkbox"/> No
Joint aches? <input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent back pain? <input type="checkbox"/> Yes <input type="checkbox"/> No
Swelling of your joints? <input type="checkbox"/> Yes <input type="checkbox"/> No	Fall(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No
Skin rash? <input type="checkbox"/> Yes <input type="checkbox"/> No	Wound or sore on skin? <input type="checkbox"/> Yes <input type="checkbox"/> No
Dry skin? <input type="checkbox"/> Yes <input type="checkbox"/> No	Pain or lumps in your breasts? <input type="checkbox"/> Yes <input type="checkbox"/> No
New or changing mole(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No	Nipple discharge? <input type="checkbox"/> Yes <input type="checkbox"/> No
Itching? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Swollen glands? <input type="checkbox"/> Yes <input type="checkbox"/> No	Bruising without any explanation? <input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding from your gums or frequent nose bleeds? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Frequent headaches? <input type="checkbox"/> Yes <input type="checkbox"/> No	Feeling that you are spinning or the room is spinning? <input type="checkbox"/> Yes <input type="checkbox"/> No
Loss of memory or feel confused frequently? <input type="checkbox"/> Yes <input type="checkbox"/> No	Loss of balance? <input type="checkbox"/> Yes <input type="checkbox"/> No
Numbness or tingling? <input type="checkbox"/> Yes <input type="checkbox"/> No	Tremor (shaking in your head/hand/foot)? <input type="checkbox"/> Yes <input type="checkbox"/> No
Feelings of being down, depressed, or hopeless? <input type="checkbox"/> Yes <input type="checkbox"/> No	Feelings of being overwhelmed by stress in your life? <input type="checkbox"/> Yes <input type="checkbox"/> No
Trouble falling or staying asleep, or sleeping too much? <input type="checkbox"/> Yes <input type="checkbox"/> No	Feelings of nervousness, anxiety, being on edge, or worried a lot about different things? <input type="checkbox"/> Yes <input type="checkbox"/> No
Thoughts that you would be better off dead or of hurting yourself in some way? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Sensitivity to heat or cold, more than most people? <input type="checkbox"/> Yes <input type="checkbox"/> No	WOMEN ONLY:
Excessive thirst? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have excessive hair on the face, chest, or abdomen? <input type="checkbox"/> Yes <input type="checkbox"/> No
Decreased interest in sex? <input type="checkbox"/> Yes <input type="checkbox"/> No	
SIGNATURE	
<div style="display: flex; justify-content: space-between; margin-bottom: 20px;"> <div style="width: 45%;"> <p style="margin: 0;">Signature</p> <p style="margin: 0;">If completed by someone other than the patient:</p> <p style="margin: 0;">Your Name: _____</p> </div> <div style="width: 45%; text-align: right;"> <p style="margin: 0;">Date</p> <p style="margin: 0;">Relationship: _____</p> </div> </div>	

Please carefully read the information that follows before making your decision.

You may use this Consent Form to decide whether or not to allow Participating HEALTHeLINK Providers and Payers ("Participants") who are involved in your care to see and obtain access to your electronic health records for treatment and/or care management purposes. This form may be filled out now or at a later date. You can give consent or deny consent to some or all of the Participants. A complete list of Participants can be found at www.wnyhealthelink.com/Home/Patients/Participants. If you have any questions on completing this form go to www.wnyhealthelink.com/Home/Patients/PatientConsent. If you do not have internet access and would like a list of Participants or need help completing this form, please call (716)206-0993 ext 311. **Your choice will not affect your ability to get medical care or health insurance coverage. Your choice to give or to deny consent may not be the basis for denial of health services.**

In this Consent Form, you can choose whether to allow the Participants to obtain access to your medical records through a computer network operated by HEALTHeLINK, which is a part of a statewide healthcare computer network. This helps collect the medical records you have in different places where you get health care, and make them available electronically to the Participants rendering services to you.

S E L E C T O N L Y O N E	YES <input type="checkbox"/> I GIVE CONSENT for all Participants who are <u>involved in my care</u> to access ALL of my electronic health information through HEALTHeLINK. By checking this box you agree that, "Yes, the staff involved in my care including emergency care, quality improvement, care management, and pre-authorization activities at all the Participants may see and get access to all of my medical records through HEALTHeLINK."				
	YES EXCEPT <input type="checkbox"/> I GIVE CONSENT for all Participants who are <u>involved in my care</u> to access ALL of my electronic health information through HEALTHeLINK except the following Participants:				
	<table border="0" style="width: 100%;"> <tr> <td style="width: 60%;">Participant's Name</td> <td>Participant's address or phone number</td> </tr> <tr> <td colspan="2" style="height: 100px; vertical-align: top;"> These Participants cannot access my electronic health information via HEALTHeLINK <i>EXCEPT in a medical emergency</i>. If you have chosen to exclude any Participants, you must contact HEALTHeLINK at (716)206-0993 ext 311 to verify your form. If you wish to deny consent to additional Participants, please identify them on the Participant Exclusion Form and attach it to this form. You can find the form at www.wnyhealthelink.com/Home/Patients/PatientConsent. If you have attached the Participant Exclusion Form please check here <input type="checkbox"/> </td> </tr> </table>	Participant's Name	Participant's address or phone number	These Participants cannot access my electronic health information via HEALTHeLINK <i>EXCEPT in a medical emergency</i> . If you have chosen to exclude any Participants, you must contact HEALTHeLINK at (716)206-0993 ext 311 to verify your form. If you wish to deny consent to additional Participants, please identify them on the Participant Exclusion Form and attach it to this form. You can find the form at www.wnyhealthelink.com/Home/Patients/PatientConsent . If you have attached the Participant Exclusion Form please check here <input type="checkbox"/>	
Participant's Name	Participant's address or phone number				
These Participants cannot access my electronic health information via HEALTHeLINK <i>EXCEPT in a medical emergency</i> . If you have chosen to exclude any Participants, you must contact HEALTHeLINK at (716)206-0993 ext 311 to verify your form. If you wish to deny consent to additional Participants, please identify them on the Participant Exclusion Form and attach it to this form. You can find the form at www.wnyhealthelink.com/Home/Patients/PatientConsent . If you have attached the Participant Exclusion Form please check here <input type="checkbox"/>					
	NO EXCEPT <input type="checkbox"/> I DENY CONSENT for all Participants <u>who are involved in my care</u> to access my electronic health information through HEALTHeLINK for any purpose, EXCEPT in a medical emergency. By checking this box you agree, "No, none of the Participants may be given access to my medical records through HEALTHeLINK unless it is a medical emergency."				
	NO NEVER <input type="checkbox"/> I DENY CONSENT for all Participants who are involved in my care to access my electronic health information through HEALTHeLINK for any purpose, INCLUDING in a medical emergency.				

NOTE: Unless you select "NO NEVER" New York State law allows the people treating you in an emergency to get access to your medical records, including records that are available through HEALTHeLINK.

PATIENT/LEGAL REPRESENTATIVE	
<div style="border: 1px solid black; height: 20px; margin-bottom: 5px;"></div> Patient Last Name:	Entity Consent Received By _____
<div style="border: 1px solid black; height: 20px; margin-bottom: 5px;"></div> Patient First Name:	
<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 30px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 30px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 20px;"></div> </div> Patient Date of Birth:	<div style="text-align: center; margin-bottom: 10px;"> <input type="checkbox"/> Male <input type="checkbox"/> Female </div> <div style="border: 1px solid black; height: 20px; margin-bottom: 5px;"></div> Patient Address
<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 100px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 20px;"></div> </div> Patient Address	
<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 100px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 20px;"></div> </div> City	<div style="text-align: center; margin-bottom: 10px;"> WITNESS * </div> <p style="font-size: small;">* If you are NOT completing this form in a Participant's office, you must have a witness complete the information below.</p> <div style="border: 1px solid black; height: 20px; margin-bottom: 5px;"></div> Print Name of Witness
<div style="border: 1px solid black; width: 100px; height: 20px; margin-bottom: 5px;"></div> State	
<div style="border: 1px solid black; width: 100px; height: 20px; margin-bottom: 5px;"></div> ZIP	
<div style="border: 1px solid black; width: 100px; height: 20px; margin-bottom: 5px;"></div> Signature of Patient or Patient's Legal Representative	
<div style="border: 1px solid black; width: 100px; height: 20px; margin-bottom: 5px;"></div> Date of Signature	<div style="border: 1px solid black; height: 20px; margin-bottom: 5px;"></div> Signature of Witness
<div style="border: 1px solid black; width: 100px; height: 20px; margin-bottom: 5px;"></div> Print Name of Patient's Legal Representative (if applicable)	
<div style="border: 1px solid black; width: 100px; height: 20px; margin-bottom: 5px;"></div> Relationship of Legal Representative to Patient (if applicable)	
<div style="display: flex; align-items: center;"> <input type="checkbox"/> parent <input type="checkbox"/> healthcare agent/proxy <input type="checkbox"/> guardian <input type="checkbox"/> other _____ </div>	<div style="border: 1px solid black; width: 100px; height: 20px; margin-bottom: 5px;"></div> Relationship of Witness to Patient (ex., spouse, son, neighbor, etc.)

Health Care Proxy Form Instructions

Item (1)

Write the name, home address and telephone number of the person you are selecting as your agent.

Item (2)

If you want to appoint an alternate agent, write the name, home address and telephone number of the person you are selecting as your alternate agent.

Item (3)

Your Health Care Proxy will remain valid indefinitely unless you set an expiration date or condition for its expiration. This section is optional and should be filled in only if you want your Health Care Proxy to expire.

Item (4)

If you have special instructions for your agent, write them here. Also, if you wish to limit your agent's authority in any way, you may say so here or discuss them with your health care agent. If you do not state any limitations, your agent will be allowed to make all health care decisions that you could have made, including the decision to consent to or refuse life-sustaining treatment.

If you want to give your agent broad authority, you may do so right on the form. Simply write: *I have discussed my wishes with my health care agent and alternate and they know my wishes including those about artificial nutrition and hydration.*

If you wish to make more specific instructions, you could say:

If I become terminally ill, I do/don't want to receive the following types of treatments....

If I am in a coma or have little conscious understanding, with no hope of recovery, then I do/don't want the following types of treatments:....

If I have brain damage or a brain disease that makes me unable to recognize people or speak and there is no hope that my condition will improve, I do/don't want the following types of treatments:....

I have discussed with my agent my wishes about _____ and I want my agent to make all decisions about these measures.

Examples of medical treatments about which you may wish to give your agent special instructions are listed below. This is not a complete list:

- artificial respiration
- artificial nutrition and hydration (nourishment and water provided by feeding tube)
- cardiopulmonary resuscitation (CPR)
- antipsychotic medication
- electric shock therapy
- antibiotics
- surgical procedures
- dialysis
- transplantation
- blood transfusions
- abortion
- sterilization

Item (5)

You must date and sign this Health Care Proxy form. If you are unable to sign yourself, you may direct someone else to sign in your presence. Be sure to include your address.

Item (6)

You may state wishes or instructions about organ and /or tissue donation on this form. New York law does provide for certain individuals in order of priority to consent to an organ and/or tissue donation on your behalf: your health care agent, your decedent's agent, your spouse, if you are not legally separated, or your domestic partner, a son or daughter 18 years of age or older, either of your parents, a brother or sister 18 years of age or older, a guardian appointed by a court prior to the donor's death.

Item (7)

Two witnesses 18 years of age or older must sign this Health Care Proxy form. The person who is appointed your agent or alternate agent cannot sign as a witness.

Health Care Proxy

(1) I, _____

hereby appoint _____
(name, home address and telephone number)

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise. This proxy shall take effect only when and if I become unable to make my own health care decisions.

(2) Optional: Alternate Agent

If the person I appoint is unable, unwilling or unavailable to act as my health care agent, I hereby

appoint _____
(name, home address and telephone number)

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise.

(3) Unless I revoke it or state an expiration date or circumstances under which it will expire, this proxy shall remain in effect indefinitely. *(Optional: If you want this proxy to expire, state the date or conditions here.)* This proxy shall expire *(specify date or conditions)*: _____

(4) Optional: I direct my health care agent to make health care decisions according to my wishes and limitations, as he or she knows or as stated below. *(If you want to limit your agent's authority to make health care decisions for you or to give specific instructions, you may state your wishes or limitations here.)* I direct my health care agent to make health care decisions in accordance with the following limitations and/or instructions *(attach additional pages as necessary)*: _____

In order for your agent to make health care decisions for you about artificial nutrition and hydration *(nourishment and water provided by feeding tube and intravenous line)*, your agent must reasonably know your wishes. You can either tell your agent what your wishes are or include them in this section. See instructions for sample language that you could use if you choose to include your wishes on this form, including your wishes about artificial nutrition and hydration.

(5) Your Identification *(please print)*

Your Name _____

Your Signature _____ Date _____

Your Address _____

(6) Optional: Organ and/or Tissue Donation

I hereby make an anatomical gift, to be effective upon my death, of:
(check any that apply)

☐ Any needed organs and/or tissues

☐ The following organs and/or tissues _____

☐ Limitations _____

If you do not state your wishes or instructions about organ and/or tissue donation on this form, it will not be taken to mean that you do not wish to make a donation or prevent a person, who is otherwise authorized by law, to consent to a donation on your behalf.

Your Signature _____ Date _____

(7) Statement by Witnesses *(Witnesses must be 18 years of age or older and cannot be the health care agent or alternate.)*

I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting of his or her own free will. He or she signed (or asked another to sign for him or her) this document in my presence.

Date _____ Date _____

Name of Witness 1
(print) _____ Name of Witness 2
(print) _____

Signature _____ Signature _____

Address _____ Address _____



**Department
of Health**