AstranaCare

Advance Directive Acknowledgement

I hereby acknowledge that I have been informed by my physician of my right to execute an Advance Directive for healthcare.

Please read and check the following statements:

1. I have executed an Advance Directive.
   ☐ Yes ☐ No
2. I have been given written materials about my rights.
   ☐ Yes ☐ No
3. I would like to receive additional information regarding Advance Directives.
   ☐ Yes ☐ No
4. I have received the additional information regarding Advance Directives.
   ☐ Yes ☐ No

Patient Name: _____

Patient Initials: _____

Patient Account Number: _____

Date of Birth: ____ / ____ / _____

Date: ____ / ____ / _____