West Coast Medical
Associates, Pasco, P.A.
5824 State Road 54 • Suite 101 • New Port Richey, FL 34652 • (727) 845-1933 • Fax (727) 845-7307

Consent to Disclose Protective Health Information

Patient Name: _____ DOB: _____

Street Address: _____ City: _____ State: ____ Zip: _____

Primary Care Provider: _____

By signing below, I hereby authorize West Coast Medical Associates, Pasco, P.A. to disclose my protected health information to the following family members and/or friends:

Name	Relationship to Patient	Phone Number

I understand I may revoke this authorization by notifying the Medical Records Department at any time in writing; however, if I do, it will not have any effect on actions taken by West Coast Medical Associates, Pasco P.A. before they received the revocation notification.

I have read this form, and all my questions about this form have been answered. By signing below, I acknowledge that I have read, and I accept, all the above statements.

Patient Signature: _____ Date: _____

West Coast Medical Associates, Pasco, P.A.
5824 State Road 54 • Suite 101 • New Port Richey, FL 34652 • (727) 845-1933 • Fax (727) 845-7307

PATIENT SELF DETERMINATION ACT QUESTIONAIRE

In order to comply with the Omnibus Budget Reconciliation Act of 1990 and Chapter 745, Florida Statutes, please review the following questions:

Declaration to Decline Life-Prolonging Procedure (LIVING WILL)

☐ I have made such a declaration

☐ I have NOT made such a declaration

Health Care Surrogate

☐ I have designated a Health Care Surrogate

☐ I have NOT designated a Health Care Surrogate

Durable Power of Attorney

☐ I have appointed a Durable Power of Attorney for Health Care decisions

☐ I have NOT appointed a Durable Power of Attorney for Health Care decisions

I have been provided information regarding the PATIENT SELF DETERMINATION ACT:

_____ _____
Print Full Name Social Security #

_____ _____
Patient Signature or Representative Date

Relationship of Patient Representative (if applicable) _____

YEARLY RECONFIRMATION

I acknowledge that this information remains accurate

_____ _____ _____ _____
Patient Signature or Representative Date Patient Signature or Representative Date

_____ _____ _____ _____
Patient Signature or Representative Date Patient Signature or Representative Date

☐ I have been provided with information regarding the PATIENT SELF DETERMINATION ACT, but declined to answer the above questions.

_____ _____
Patient Signature or Representative Date

West Coast Medical Associates, Pasco, P.A.
5824 State Road 54 • Suite 101 • New Port Richey, FL 34652 • (727) 845-1933 • Fax (727) 845-7307

Please Let Us Know Your Wishes:

Check ALL that apply:

_____ I have a living will. (If yes, please provide a copy.)
_____ I have a document I signed that allows another person to make healthcare decisions for me. (If yes, please provide a copy.)
_____ If I ever become too sick to make my own healthcare decisions, I give the following person permission to make them for me: have a living will. (If yes, please provide a copy.)
Name: _____
Phone Number: _____

If I become so ill that I cannot tell my doctor what I want, and two doctors agree they cannot make me better, please: (Check ALL that apply)

_____ Keep me comfortable and free from pain.
_____ Do NOT use tube for: _____ Breathing _____ Feeding _____ IV Fluids
_____ Let my appointed person decide.
_____ If my heart stops, _____ do _____ do not try to restart it.
_____ Do EVERYTHING possible.
_____ I do not wish to complete an advanced directive at this time.

Additional Instructions:

_____
_____
_____

Signatures:

Printed Name: _____ Date: _____

Signature: _____ Date: _____

1st Witness: _____ Date: _____
Relationship of 1st Witness: _____

2nd Witness: _____ Date: _____
Relationship of 2nd Witness: _____

Please note, the person designated as surrogate shall not act as a witness and at least one person who acts as a witness shall neither be the principal's spouse or blood relative.

Your surrogate may consult with your health care providers and give informed consent to perform medical procedures the surrogate feels are in your best interest and make health care decisions for you the surrogate believes that you would have made yourself under the circumstances if you were capable of making such decisions. Your surrogate has access to your clinical records and has the authority to release information and records to appropriate persons to ensure the continuity of your health care. If there is no indication of what you would have chosen, the surrogate may consider what is in your best interest in deciding that proposed treatments are to be withheld or that treatments currently in effect are to be withdrawn.