USF Health Endoscopy and Surgery Center

This facility is required by the State of Florida to ask <u>you</u> to complete the information below and <u>we</u> are required to provide you with documents specified:

RECEIPT OF PATIENT RIGHTS AND RESPONSIBILITIES AND NOTICE OF PRIVACY PRACTICES:

I give permission for my protected health information to be disclosed for purposes of communication results, findings and care decisions to family members and others listed below:

Name: _____ **Name:** _____

Name: _____ **Name:** _____

Name: _____ **Name:** _____

ADVANCE DIRECTIVES and CONSENT TO TRANSFER:

Please check either "I do" **or** "do not" for both items below. Please do not leave blank.

I DO _____, DO NOT ____ have an Advance Directive, Living Will or Health Care Power of Attorney.

I DO _____, DO NOT _____ want to have information on Advance Directives.

It is our Policy, regardless of the contents of any Advance Directive or instructions from a Health Care Surrogate or Attorney in fact, that if an adverse event occurs during your treatment at this facility, we will initiate resuscitative or other stabilizing measures and transfer you to an acute care hospital for further evaluation. Your Advance Directive or Health Care Power of Attorney will become effective again after your transfer from this facility. My signature below acknowledges that I am in agreement with this policy and does not revoke or invalidate any current health care directive or health care power of attorney

By my signature on this document, I acknowledge advance receipt of my Patient Rights and Responsibilities, a Notice of Privacy Practices brochure, and the above questions on Advance Directives, in advance of my procedure. I may receive a copy of Advance Directive information upon admission to the center, if desired.

_____ _____

Patient/Guardian Signature Date