

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 Dir	ective, Living Will or Health Care Power of Attorney.
I DO, DO NOT want to have information on Advance Directives.	
hospital for further evaluation. Your Advance Dire	erse event occurs during your treatment at this ilizing measures and transfer you to an acute care ective or Health Care Power of Attorney will become by. My signature below acknowledges that I am in
By my signature on this document, I acknowledge Responsibilities, a Notice of Privacy Practices brod Directives, in advance of my procedure. I may readmission to the center, if desired.	
Patient/Guardian Signature	Date