Hawthorne Family Practice

Hawthorne Family Practice now has made the questioning of patients as to whether they have an advanced directive or living will part of our practice. If you have an advanced directive of living will, please bring a copy of it with you to the office.

If you do not have an advance directive or living will, please read the following information. An advance directive or living will is a document which allows you to give written instruction to those caring for you indicating the type of health care you would wish to receive or reject in the event you become unable to express these decision for yourself. There are three different types of advance directives:

- **A PROXY DIRECTIVE**
  In a proxy directive, a competent adult names a trusted relative or friend to make health care decisions on his or her behalf when he or she is unable to make these decisions.

- **AN INSTRUCTION DIRECTIVE**
  In an instruction directive, a competent adult provides specific written instructions concerning the type of medical treatment he or she would want performed, or would not want performed, and under what circumstances.

- **A COMBINED DIRECTIVE**
  In this document, a competent adult states his or her general wishes regarding the kind or health care he or she wishes to receive but appoints a trusted relative or friend to carry them out

A brochure containing living will forms and instructions is available from The NJ Bioethics Commission. If you wish to receive the brochure, please send a 9-inch by 12-inch self-addressed envelope with $1 in postage attached to:

Dept of Health
Division of Health
(800) 792-8820 or (609) 943-3437

Do you have an advance Directive or Living Will…… Yes☐ No☐
If yes, please bring it to Hawthorne Family Practice

X_____
Patient's Signature (Indicating awareness of above)

Receipt of Notice of Privacy Practices Written Acknowledgement Form

I have received a copy of Hawthorne Family Practice Notice of Privacy
I authorize my emergency contact to obtain any additional information regarding my heath care plan.

I authorize the following person(s) as contacts who are permitted to receive my medical information.

_____ _____
Signature of Patient Date