Name:_____ DOB:_____

About me:

I have trouble hearing. ☐ Yes ☐ No

I wear hearing aids. ☐ Yes ☐ No

I am blind or have trouble seeing. ☐ Yes ☐ No

I wear glasses and/or contacts. ☐ Yes ☐ No

I have a health condition that makes it hard for me to concentrate, remember, or make decisions. ☐ Yes ☐ No

I sometimes have trouble paying for the care I need. ☐ Yes ☐ No

MY HEALTH WISHES

Health wishes:
- ☐ I agree to discuss end of life wishes with my health care provider
- ☐ I do not agree to discuss end of life wishes with my health care provider

I already have health wishes in writing:
- ☐ I have an advanced directive / living will
- ☐ Durable medical power of attorney
- ☐ Durable financial power of attorney
- ☐ Health care proxy
- ☐ POLST (Physician Order for Life-Sustaining Treatment)
- ☐ Something else:

Please bring a copy of any health wishes you have in writing. We will put them in your medical record. If you want your wishes in writing, ask us for information during your visit.

Consent for Release of medical Information

I, _____, grant permission for the person(s) listed below to have access to any andall of my medical information that pertains to my care from the physicians of this group. This includes, but not limited to appointment times, lab results, my physician's plan for health care, etc.

Signature: _____

Name: _____ Relationship: _____ Phone: (_____) _____

Name: _____ Relationship: _____ Phone: (_____) _____

Name: _____ Relationship: _____ Phone: (_____) _____

I AGREE TO NOTIFY THE KENNEDY CLINIC, IN WRITING, IF THERE ARE ANY CHANGES IN THE PERSON(S) AUTHORIZED

THANK YOU