

# Advance Directives Record Form

Name: (Print) \_\_\_\_\_

Signature: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Effective Date: \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

Please check one of the following:  I have executed Advanced Directive documents.

I have not executed Advanced Directive documents.

I have received information from Neighborhood Health Partnership concerning Advance Directives and Neighborhood Health Partnership's policies on medical care decisions.

**Complete and sign this form and mail it to:** NHP, Member Services, PO box 025680, Miami, FL 33102-5680.

Signed \_\_\_\_\_ Date \_\_\_\_\_

Signature (NHP) \_\_\_\_\_ Date \_\_\_\_\_

