

Health Care Questionnaire

Full Legal Name _____

Health Care Agent (Full Legal Name): _____

Agent's Home Address _____

Telephone Numbers for Agent (home, office, cell) _____

1st Alternate (Full Legal Name): _____

Alt. Agent's Home Address _____

Telephone Numbers (home, office, cell) _____

2nd Alternate (Full Legal Name): _____

Alt. Agent's Home Address _____

Telephone Numbers (home, office, cell) _____

****If you wish to name additional alternate Agents, provide the information on the back of this form.**

- If you would like to specifically name a **physician** in your Health Care Power of Attorney (not required), provide the following:

Physician's Name: _____

Physician's Address: _____

Physician's Telephone Number: _____

Special Provisions (to be discussed with attorney): _____

Do you want a **Living Will**: _____ YES _____ NO

Do you want a **HIPAA Release**: _____ YES _____ NO If YES, please provide the full name(s) of the person or persons who you will authorize to access your private health care information:

