Print Form

Date: _____

Dr. _____

Address: _____

_____

I, _____, do hereby authorize the above named physician and staff to download a 'File for Life' form and a POLST form (Physicians Orders for Life Sustaining Treatment) from www.calaverasvolunteer.com, and to complete said forms for my review and subsequent approval and/or signature.

This authorization is intended to satisfy the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and California's Confidentiality of Medical Information Act (CMIA).

I hereby release Dr._____ and staff from any and all liability in connection with the information supplied on said form and take full responsibility for the accuracy of data thereon.

I understand that I will receive a copy of said completed forms. I will be keeping these forms and other important data in my 'Yellow Dot' folder which will be available in the event I am in an accident or in need of medical assistance from First Responders.

Thank you for your assistance,

Signature _____ Date: _____

Printed Name: _____

Residence Address: _____

_____

Mailing Address: _____

_____

Home Phone: ( ) _____

Office/Work Phone ( ) _____

Cell Phone ( ) _____