Sample Directive Regarding Healthcare Choice

To the Healthcare Clinic, Hospital, Physician of the Undersigned:

RE: Request for Physician (MD or DO) Care

I am requesting that this document be placed on file in my medical record at this practice, facility or hospital and stand as a directive until revoked by myself, or other power of healthcare appointed by myself. It has been signed by the witnesses below and dated.

I respect that nurse practitioners and physician assistants may be part of a supervised team and work to help my physician by taking notes, refilling routine medications, giving immunizations, taking a history, and consent ONLY to their use in my healthcare in those limited areas.

I do not consent to the use of either a nurse practitioner or physician assistant for any other areas of my healthcare to include but not limited to:

Diagnosis of diseases
Determination of which labs to be ordered, (other than yearly routine), x-rays or other studies.
Determination of and initiation of prescriptions and treatments plans, as well as any changes to those plans.
Referrals to specialists.
Evaluation of labs, x-rays, and studies.
Admission order to hospitals and rehabilitation centers

This directive includes states where there is allowed any type of independent practice as well as those that do not. I further do NOT expect that this directive should prejudice my healthcare by delaying any care I should receive in a timely manner. If you have any questions, please contact me or the person I may designate below. I look forward to continued quality care at your facility.

Respectfully,

Patient Signature: _______________________________ Date: _________________

Printed Name: ____ *Phone:* ________________

Address: ____

Additional Contact Person If applicable: ________________________________*Phone:* ________________

Witness Signature: ____ *Date:* _________________

Witness Printed Name: ____

Witness Signature: ____ *Date:* _______________

Witness Printed Name: ____