



## Consent to Obtain External Prescription History

I, \_\_\_\_\_, whose signature appears below, authorize The Pichardo Clinic and Its Affiliated Providers to view my external prescription history via the RxHub service.

I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years.

MY SIGNATURE CERTIFIES THAT I READ AND UNDERSTOOD THE SCOPE OF MY CONSENT AND THAT I AUTHORIZE THE ACCESS.

\_\_\_\_\_  
Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date



**LIVING WILL**

Declaration made this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_,  
(day) (month) (year)

I, \_\_\_\_\_, willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare that:

If at any time I am incapacitated and

- \_\_\_\_\_ I have a terminal condition, or
- \_\_\_\_\_ I have an end-stage condition, or
- \_\_\_\_\_ I am in a persistent vegetative state

and if my attending or treating physician and another consulting physician have determined that there is no reasonable medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

It is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal. In the event that I have been determined to be unable to provide express and informed consent regarding the withholding, withdrawal, or continuation of life-prolonging procedures, I wish to designate, as my surrogate to carry out the provisions of this declaration:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_

I wish to designate the following person as my alternate surrogate, to carry out the provisions of this declaration should my surrogate be unwilling or unable to act on my behalf:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_

Signed: \_\_\_\_\_

**Witness 1:**

Signed: \_\_\_\_\_

Name: \_\_\_\_\_

**Witness 2:**

Signed: \_\_\_\_\_

Name: \_\_\_\_\_



**AUTHORIZATION TO DISCUSS MEDICAL INFORMATION**

Declaration made this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_,  
(day) (month) (year)

I, \_\_\_\_\_, give permission to  
the Pichardo Clinic to discuss any of my medical information with the following  
individuals:

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_ Zip Code: \_\_\_\_\_  
Phone: \_\_\_\_\_

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_ Zip Code: \_\_\_\_\_  
Phone: \_\_\_\_\_

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_ Zip Code: \_\_\_\_\_  
Phone: \_\_\_\_\_

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_ Zip Code: \_\_\_\_\_  
Phone: \_\_\_\_\_

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_ Zip Code: \_\_\_\_\_  
Phone: \_\_\_\_\_

**Signed:** \_\_\_\_\_

**Witness 1:**

Signed: \_\_\_\_\_  
Name: \_\_\_\_\_

**Witness 2:**

Signed: \_\_\_\_\_  
Name: \_\_\_\_\_



**DESIGNATION OF HEALTH CARE**

Name: \_\_\_\_\_  
(Last) (First) (Middle Initial)

In the event that I have been determined to be incapacitated to provide informed consent for medical treatment and surgical and diagnostic procedures,

I wish to designate as my surrogate for health care decisions:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_

If my surrogate is unwilling or unable to perform his or her duties, I wish to designate as my alternate surrogate:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_

I fully understand that this designation will permit my designee to make health care decisions, except for anatomical gifts, unless I have executed an anatomical gift declaration pursuant to law, and to provide, withhold, or withdraw consent on my behalf; to apply for public benefits to defray the cost of health care; and to authorize my admission to or transfer from a health care facility. I further affirm that this designation is not being made as a condition of treatment or admission to a health care facility. I will notify and send a copy of this document to the following persons other than my surrogate, so they may know who my surrogate is:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Signed: \_\_\_\_\_

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

**Witness 2:**

Signed: \_\_\_\_\_

Name: \_\_\_\_\_

**Witness 2:**

Signed: \_\_\_\_\_

Name: \_\_\_\_\_



**AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION TO THE PICHARDO CLINIC**

*Fill out this form if you want your records from your previous doctor be sent to our office.*

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Previous Name: \_\_\_\_\_ SSN: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_  
 State: \_\_\_\_\_ Phone: \_\_\_\_\_

**I request and authorize release healthcare information of the patient named above from:**

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax#: \_\_\_\_\_

Records as listed below should be mailed or faxed to: **The Picardo Clinic**, to the address or fax listed at the bottom.

This request and authorization applies to:

Healthcare information relating to the following treatment, condition, or dates: \_\_\_\_\_  
 \_\_\_\_\_

All healthcare information

Other: \_\_\_\_\_

**Definition:** Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhoea.

Yes  No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

Yes  No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

Witness: \_\_\_\_\_ Date Signed: \_\_\_\_\_

I UNDERSTAND THAT I MAY REVOKE THIS CONSENT AT ANY TIME, EXCEPT WHERE INFORMATION HAS ALREADY BEEN RELEASED. THIS AUTHORIZATION IS VALID FOR UNTIL REVOKED IN WRITING BY ME.