MRN #_____

## Consent for Results

Patient Name: _____ DOB:_____

By signing this form, I authorize medical test results to be given to the parties indicated below. I understand that I may revoke this at any time by a written statement.

List Person(s) to give test results to: _____(Name/Relation)

_____(Name/Relation)

_____Do NOT give medical test results to anyone except me.

Primary phone number for test results:_____

Patient or Parent of Patient_____Date:_____
*(Signature)*

---

## MIPS

Who is your Primary Care Provider? _____

Please check one that applies to you below:

Influenza (Flu) Vaccine:
____ I will/have receive(d) a flu vaccine this flu season
Or
____ I will NOT receive a flu vaccine this flu season
Pneumococcal Vaccine (Pneumonia-Age 65 and Older):
____ I will/have received the pneumovax vaccine in the last 5 years
Or
____ I have NOT received the pneumovax vaccine in the last 5 years
Advanced Directives:
Advanced directives are designed to respect your wishes regarding future life sustaining medical treatments if you were unable to indicate your wishes. Key interventions and treatment decisions are resuscitation procedures such as Cardiopulmonary Resuscitation (CPR) and mechanical respiration (breathing tube).

Which statement best reflects your wishes:
____ I want full CPR to be made
Or
____ I do NOT want full CPR to be made

____ I have a living will

____ I have a health care proxy (someone who is legally in charge of my health decisions)

Whose name is _____ and the contact number is _____.

Patient Signature: _____ Date:_____