



## ADVANCE DIRECTIVE ATTESTATION

ENROLLEE NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

CLINICAN NAME: \_\_\_\_\_

AGENCY: \_\_\_\_\_ DATE COMPLETED: \_\_\_\_\_

By signing this document, I am verifying that:

- I have received an explanation about the Washington State Advance Directive.
- I understand the information that was provided to me and that I have had adequate opportunity to ask questions about the Advance Directive.
- I have elected to:

\_\_\_\_\_ Complete the paperwork provided regarding the Advance Directive (it is my choice to complete and/or submit this information to the Agency).

\_\_\_\_\_ Not complete the paperwork at this time, although I may do so at any time in the future.

\_\_\_\_\_ Not disclose my completed Advance Directive to the Agency.

\_\_\_\_\_ Disclose my completed Advance Directive to the Agency.

A copy of this attestation shall be placed in my chart and I shall also receive a copy.

\_\_\_\_\_  
Consumer Signature

\_\_\_\_\_  
Date of Signature