Client Name:		Client ID/MRN:		Date of Birth:	

Advance Directive

I am at least 16 years old and I have been informed about the Advance Directive document and choose:

☐ **TO COMPLETE an Advance Directive with my Mental Health Provider**

☐ **NOT TO COMPLETE an Advance Directive with my Mental Health Provider.**

____ ____________________

Client Signature **Date**

____ ____________________

Parent/Legal Representative Signature **Date**

____ __________ _________

Mental Health Provider **Date**