ADVANCE HEALTH CARE DIRECTIVE
Client Acknowledgment Form

This information applies to adult clients (ages 18 years and older) only.

Do you have an advance directive? ❑ Yes ❑ No	
If yes, have you provided Lake County Behavioral Health (LCBH) with a copy of your advance directive? ❑ Yes ❑ No	
Date that LCBH received your advance directive:	
In the event of an emergency, may LCBH share your advance directive with other health care providers? ❑ Yes ❑ No	
Client Signature:	Date:
Staff Signature:	Date:
Lake County Behavioral Health **ADVANCE DIRECTIVE CLIENT ACKNOWLEDGMENT** *Page 1 of 1*	Client Name: Client ID#:

CONFIDENTIAL PATIENT INFORMATION
(SEE CALIFORNIA WELFARE AND INSTITUTIONS CODE SECTION 5328)