"Making Individuals' Lives Better"

ADVANCE DIRECTIVE ACKNOWLEDGEMENT FORM

Client Name:_____

Date:_____

I, _____, acknowledge that Kirstin Care OMHC (KIRSTIN CARE) has provided me with a copy of the Maryland Department of Mental Health and Hygiene Advance Directive for Mental Health Treatment. I acknowledge that I have read and understand the notice and my rights contained within. ◯ Yes ◯ No

I have an Advance Directive (if yes, a copy must be provided) ◯ Yes ◯ No

I choose to decline the Advance Directive ◯ Yes ◯ No

_____ _____

Client Signature Date

_____ _____

Staff Signature Date

COMAR 10.21.17.04 C

Revised 5/09/19

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