3349A 6/23

Winona Health

I have a Health Care Directive.

Name _____

Address _____

_____

Phone (_____) _____

Dated _____

In case of an
EMERGENCY

Health Care Directive

My health care directive is filed at:

Location _____

Address _____

Phone (_____) _____

My health care agent is:

Name _____

Address _____

Home (_____) _____

Work (_____) _____

My alternate agent is:

Name _____

Address _____

Home (_____) _____

Work (_____) _____

My physician is:

Name _____

Address _____

Phone (_____) _____