NORTH SUNFLOWER MEDICAL CENTER
Patient Self Determination Act of 1990
ADVANCED DIRECTIVES & ACKNOWLEDGEMENT/AGREEMENT

(Check YES or NO for each item)

1. I have received the information on Advanced Directives, including the information on my rights as a patient to accept or refuse medical or surgical treatment. This includes:
   
   A. “Patient Self Determination Act: Written Description of the Law of the State of Mississippi”
      YES__________ NO___________

      YES__________ NO ___________

2. I have received this facility’s written policies respecting the implementation of my rights under the Patient Self Determination act of 1990 and Mississippi State law.
   YES _________ NO ____________

3. Have you executed in Mississippi:
   
   A. A living will _________________________________________________
      YES _________ NO ____________
      IF YES, SPECIFY DATE/TIME

   B. A durable power of attorney for health care matters
      ___________________________________________
      YES _________ NO ____________
      IF YES, SPECIFY DATE/TIME

   C. If 3A or 3B above is marked “YES” have either of these Directives been revoked?
      YES _________ NO ____________

4. I have other advanced directives ________________________________
   YES _________ NO ____________
   ______________________________________________________________
   IF YES, SPECIFY

5. I have been informed that the facility, its medical staff, and employees will not discriminate against me with respect to provision of health care or otherwise based upon whether I do or not have advanced directives.
   YES _________ NO ____________

6. I hereby agree to full and complete immunity from any and all legal actions against North Sunflower County Hospital, it’s medical staff and employees when they act in good faith in complying with my advanced directive(s) made for me by person(s) legally authorized by Mississippi and federal statutes.
   YES _________ NO ____________

*1ADV*
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______________________________________  ________________________________________
SIGNATURE OF PATIENT  DATE

OR

______________________________________  ________________________________________
SIGNATURE OF PATIENT’S REPRESENTATIVE  DATE

______________________________  ________________________________
RELATIONSHIP TO PATIENT (SPOUSE, CHILD, PARENT, ETC)

______________________________
AUTHORITY/REASON

On behalf of ____________________________________________
Name of Patient

If patient is unable to sign and there is no patient representative, state this fact:
__________________________________________

________________________________________________________________________________

Signature of RN Executing Acknowledgement  Date

______________________________  ________________________________
Witness – if patient or representative signs by using an “X”, two witnesses are required.

*1ADV*