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_____

   B. Written description of my rights under the Patient Self Determination Act of 1990. 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   C. If 3A or 3B above is marked "YES" have either of these Directives been revoked?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 he 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

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

«

_____ _____
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. Date

1ADV