ADVANCED DIRECTIVE ACKNOWLEDGEMENT

I understand that I have the right to make choices regarding life-sustaining treatment (including resuscitative measures). If I desire to exercise this right, I understand that I must inform my physician of my wishes. I understand that if I have a Living Will, Durable Power of Attorney, and/ or Advanced Directive, I must inform **Harborside Surgery Center**. I am aware that in the event of a life-threatening emergency, it is the policy of **Harborside Surgery Center** to perform any necessary emergency procedures and transfer me to an acute facility/hospital.

I understand that I may revoke this consent at any time by notifying **Harborside Surgery Center**, in writing, but if I revoke my consent, such revocation will not affect any actions that **Harborside Surgery Center** took before receiving my revocation.

_____

_____ _____

Signature of patient or patient's representative Date

_____ _____

Printed Name of patient or patient's representative Date

_____ _____

Signature of witness Date