Stark Ambulatory Surgery Center
Canton, Ohio 44718

ADVANCE DIRECTIVES AND LIVING WILL INFORMATION

It is our policy is to ensure that all personnel and patients are aware that the Stark County Ambulatory Surgery Center does not accept or honor any advance directives and/or living wills. However, the patient must provide this information on the day of the procedure in the event that the patient is transferred to a different acute care facility(hospital).
This form needs to be completed and brought to the office on the day of your procedure.

_____ I have a living will, but should the need arise for resuscitation of my lungs or heart during my stay here at the Stark Ambulatory Surgery Center, I hereby allow the nurses and the physicians to perform resuscitation measures and transport me to an acute care setting (hospital)as soon as possible.

_____ I do not have a living will.

Patient Signature:_____Date:_____

Witness:_____ Date:_____

If you do not have such a document information can be requested at the time of your procedure or information can be found at the following website:
http://www.mayoclinic.com/health/living-wills/HA00014

PATIENT APPOINTMENT OF REPRESENTATIVE

I hereby appoint the person listed below to be my representative. I authorize you to use and disclose my private healthcare information (PHI) to this representative. I have the right to rescind this appointment at anytime with written notice to the Stark Ambulatory Surgery Center. (SASC)

This person may receive my PHI and discuss this information in my treatment and/or payment.

Name of Representative:_____

Birth Date of Representative: Month:_____ Day:_____

Relationship to Patient:_____

Does This Person have Medical Power of Attorney? _____

Time frame of Appointment: From this day forward with no restrictions:_____

Date to/from:_____

Name of Patient:_____

Signature of Patient:_____

Date:_____