



VAIL VALLEY SURGERY CENTER

WAIVER OF ADVANCE DIRECTIVE

I, _____, hereby voluntarily waive any Advance Directive prohibiting resuscitation efforts that I may have signed or that my representative may have provided to Vail Valley Surgery Center, its physicians, employees or other affiliates, for the limited purpose of procedures performed on _____ [DATE] at Vail Valley Surgery Center.

I understand that by this waiver I am authorizing Vail Valley Surgery Center, its physicians and personnel to initiate resuscitative or other stabilizing measures and transfer me to an acute care hospital for further evaluation, as needed.

I further understand that I am not obligated to sign this Waiver of Advance Directive and am free to seek medical care at another facility.

The undersigned certifies that he/she is the patient, the patient's legal representative, or is duly authorized by the patient's general agent to execute this document and accept and agree to its terms.

Date

Patient/Parent/Guardian/Conservator/Agent

Time

If other than patient, indicate relationship

Witness