ACKNOWLEDGEMENT

Physician: Dr. Manzoor A. Kazi, MD **Telephone:** (760) 340-5800

Address: 72757 Fred Waring Dr. Suite 1

Palm Desert, CA 92260.

Patient's Name: _____ **Date of Birth:**_____

_____

Address: _____ **Telephone:** _____

_____

_____

Advanced Directives

This acknowledgment that the physician, or one of his/her staff members, has provided me information concerning Advanced Directives.

1. I am age 18 or older. (Circle one) **Yes** **No**

2. I understand I have the option of putting together Advanced Directives for my healthcare. My physician has provided me written information concerning these Advanced Directives. I understand that it is my responsibility to provide my Doctor(s) with any documents that are required to carry out my Advanced Directives.

3. I am aware that Advanced Directives may be any one of the following:

    a. A Durable Power of Attorney for Health Care.
    b. The Declaration in the A natural Death Act – Ex. A Living Will
    c. I may write my wishes on paper so that my family may use the document in deciding my medical treatment in the event I am unable to do so.

Patient's Signature: _____ **Date:** _____

This document will be part of my medical record.