

**PATIENT WAIVER OF LIVING WILL  
AND DURABLE POWER OF ATTORNEY**

I, \_\_\_\_\_, hereby certify that, the Augusta Plastic Surgery Associates, P.C./Augusta Plastic Surgery Center, Inc. has informed me of its policy of its policy which instructs physicians, including my attending physician, in instances where surgical procedures are performed under either local, regional, or general anesthesia at Augusta Plastic Surgery Associates, P.C./Augusta Plastic Surgery Center, Inc. or during the recovery period following any procedure, against effectuating my living will, and against honoring the decisions of my agent for health care pursuant to a durable power of attorney for health care, or following any other advanced directive I have executed or effected. Therefore, for the purposes of this surgical procedure, I hereby waive the provisions of my living will and acknowledge that the decisions of my agent for health care will not be honored.

This \_\_\_\_\_ day of \_\_\_\_\_ 200\_\_.

\_\_\_\_\_  
Patient's Signature

Chart Number: «Person\_ID»

\_\_\_\_\_  
Witness Signature