

Digestive Disorders Associates

Date ____/____/____

Gastroenterology

Michael S. Epstein, M.D., F.A.C.G., AGAF

Charles E. King, M.D., F.A.C.P.

Ritu M. Sachdev, M.D.

Barry J. Cukor, M.D.

Vishnupriya G. Krishna, M.D.

Nadim G. Haddad, M.D.

Jacqueline Laurin, M.D.

Aline Charabaty, M.D.

Lisa Medeiros, CRNP

Rebecca Turner, CRNP

I, _____, give the
(power of attorney/custodial/guardian)
nursing staff and/or facility staff of _____
(name of nursing facility)
and the medical providers of Digestive Disorders Associates the
authorization to make the proper medical decisions regarding
the care of _____.
(name of patient)

Due to _____'s current
(name of patient)
medical status, I feel he/she is incapable of making the proper medical
decisions.

Main Offices

621 Ridgely Avenue, Suite 201

Annapolis, Maryland 21401

410-224-4887

Fax 410-224-1428

1630 Main Street, Suite 204

Chester, Maryland 20619

Patient's Name

Family Member's Name (signed)

Family Member's Name (printed)

Relationship to patient