STATE OF _____

ADVANCE HEALTH CARE DIRECTIVE

An advance directive is a document that allows someone known as a principal to appoint a representative to make health care decisions on their behalf in case they become incapacitated or are otherwise unable to do so themselves. It also allows the principal to lay out their end-of-life treatment preferences to sustain life in the future which is dependent on state law.

I. MEDICAL POWER OF ATTORNEY

DESIGNATION OF AGENT

On the ___ day of _____, 20____ I, _____ (principal) of _____ [Address], with the last four digits of my social securing numbering being ____ and the telephone number _____ in sound mind and body, free of any undue influence or duress, as a mentally competent individual state that the directives provided within this document should be treated as a clear and formal declaration of my wishes as relates to my health care, treatment, and custody. I hereby declare that these instructions, outlined below, are binding upon all those involved to the full extent allowable by the law.

I authorize, _____ of _____ [Address], with the telephone number _____ as my agent (attorney-in-fact) to act for me and in my name according to the instructions in the document below. If the primary agent named above is unable to act on my behalf or unwilling to act on my behalf, then _____ of _____ [Address] with the telephone number _____ will be my successor agent.

AUTHORITY GRANTED

The above-named agent is authorized by me to make all healthcare decisions in line with my wishes – including mental health decisions. These decisions include but are not limited to choices to approve or with hold treatment related to sustaining my life, nutrition and hydration delivered through artificial means, antibiotics and other medication choices, decisions related to pain relief, and other treatments

to keep me alive. The appointed agent DOES NOT have authority over the treatments and situations stated below:

_____
_____
_____

EFFECTIVE DATE

(Initial one)

The authority of my agent comes into effect when the initialed condition is met.

____ When I am declared incompetent or incapacitated by my physician. This notice must be put in writing.

____ As soon as this advance directive has been duly executed.

HIPPA NOTICE

(initial one)

____ I hereby authorize my medical care providers to make available any protected health information or medical records for my agent to utilize while their authority is in effect. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (aka HIPAA), 42 USC 1420D, and 45 CFR 160-164

____ I DO NOT authorize my medical care providers to make available any protected health information or medical records for my agent to utilize.

NOMINATION OF GUARDIAN (OPTIONAL)

In the event that the court deems it necessary to appoint a guardian for me or my estate, these are the nominees I present for consideration of the appointment:

Guardian of estate nominee: _____

Address: _____

Telephone Number: _____

Guardian of my person nominee: _____

Address: _____

Telephone Number: _____

II. LIVING WILL

I choose to (Initial one):

____ Have a living will

____ Not have a living will (if this option is selected then leave section two blank)

LIFE-SUSTAINING MEDICAL TREATMENT

In some cases, people do not which to have certain life sustaining treatments used under any circumstances. If there are certain treatments or procedures that you DO NOT want medical care professionals to use to sustain your life, please initial next to them below. Leave them blank if you wish for them to use all of the available options if the situation arises.

____ Cardiopulmonary resuscitation with the aim of extending my life

____ Using external life support devices such as respirators or ventilators perform regular bodily functions to extend my life

____ Using external life support devices such as tube feeding or intravenous lines to deliver nutrition with the aim of extending my life

____ Using blood or blood products to extend my life

____ Using artificial dialysis machines to extend my life

____ Using antibiotics and other medications to extend my life

____ Other _____

I understand that if I DO NOT initial any treatment option above then I give my consent for that treatment to be used if it is required.

PREFERENCES FOR TERMINAL ILLNESS

(Initial only one of the options below. Leave blank if you have no preferences)

In the event that my death is near due to a terminal illness even with the use of life-sustaining treatments, then:

_____ I wish for my health care providers to ensure I remain comfortable and let a natural death occur. Refrain from any additional medical interventions to try to sustain or extend my life. I also do not want additional fluids and or nutrition via medical means or tubes.

Or

_____ I wish for my health care providers to ensure I remain comfortable and let a natural death occur. Refrain from any additional medical interventions to try to sustain or extend my life. If, during this time, I cannot take food or fluids by mouth, I wish to receive additional food and nutrition via tube or other medical means.

Or

_____ I wish for my health care providers to try and extend my life for as long as possible. Take advantage of all available treatment methods, procedures, and interventions that, under reasonable expectations, would prevent or delay my death. If, during this time, I cannot take food or fluids by mouth, I wish to receive additional food and nutrition via tube or other medical means.

PREFERENCES FOR PERSISTENT VEGITATIVE STATE

(Initial only one of the options below. Leave blank if you have no preferences)

If it has by determined by my physicians that I am in a persistent vegetative state – I have no awareness of my surroundings or myself, I am not conscious, and I am unable to interact with others and there is no expectation due to prevailing medical techniques and treatment methods for me to regain consciousness – then:

_____ I wish for my health care providers to ensure I remain comfortable and let a natural death occur. Refrain from any additional medical interventions to try to sustain or extend my life. I also do not want additional fluids and or nutrition via medical means or tubes.

Or

_____ I wish for my health care providers to ensure I remain comfortable and let a natural death occur. Refrain from any additional medical interventions to try to sustain or extend my life. If, during this time, I cannot take food or fluids by mouth, I wish to receive additional food and nutrition via tube or other medical means.

Or

_____ I wish for my health care providers to try and extend my life for as long as possible. Take advantage of all available treatment methods, procedures, and interventions that, under reasonable expectations, would prevent or delay my death. If, during this time, I cannot take food or fluids by mouth, I wish to receive additional food and nutrition via tube or other medical means.

PREFERENCES FOR END OF STAGE CONDITION

(Initial only one of the options below. Leave blank if you have no preferences)

If it has been determined by my physicians that I am in an end-state conditions – an condition that current medicine has no cure for and which will progress until I die and has already created a significant loss of overall capacity and total physical dependency – then:

_____ I wish for my health care providers to ensure I remain comfortable and let a natural death occur. Refrain from any additional medical interventions to try to sustain or extend my life. I also do not want additional fluids and or nutrition via medical means or tubes.

Or

_____ I wish for my health care providers to ensure I remain comfortable and let a natural death occur. Refrain from any additional medical interventions to try to sustain or extend my life. If, during this time, I cannot take food or fluids by mouth, I wish to receive additional food and nutrition via tube or other medical means.

Or

_____ I wish for my health care providers to try and extend my life for as long as possible. Take advantage of all available treatment methods, procedures, and interventions that, under reasonable

expectations, would prevent or delay my death. If, during this time, I cannot take food or fluids by mouth, I wish to receive additional food and nutrition via tube or other medical means.

COMFORT AND PAIN RELIEF

(Initial one option below to share your pain relief preferences. If you have none then leave this section blank)

In line with my aforementioned decisions, I would like to take the following approach to my comfort and pain relief:

____ I wish to utilize maximum pain relief medication and treatment options as long as it does not hasten my death.

____ I wish to utilize maximum pain relief medication and treatment options even if it hastens my death.

____ I wish to utilize maximum pain relief medication and treatment options even if it will result in addiction if I survive my current condition or an extended hospital stay.

____ Other _____

_____

IN THE CASE OF PREGNANCY

(This is optional and should only be filled out by women of child-bearing age. If it is not applicable to you then leave blank).

If it occurs that I am pregnant and need life-sustaining treatment, my preferences will change as follows:

_____

_____

_____

END OF LIFE WISHES

(this section should outline things such as hospice care, funeral arrangements, etc.)

When the time of my death draws near, it is important to me that my affairs are handled in the following manner:

_____

_____

_____

III. ORGAN DONATION UPON DEATH

After my death, it is my wish to give (Initial one):

____ any part of my body that is needed for various purposes except _____

____ Only the following parts of my body _____

In both cases, the organs should only be used for the following purposes (initial all applicable options):

____ Research

____Transplant

____ Use in education

____ Medical research

____ Other _____

IV. SIGNATURES AND ACKNOWLEDGEMENT

_____ _____

Signature of Declarant /Principal Date

_____

Name Printed

_____

Address

_____

Telephone Number

AGENT ACKNOWLEDGEMENT

I understand the responsibilities contained herein and hereby accept the appointment as healthcare agent. While fulfilling my duties, I shall act in accordance with the desires expressed by the principal in this document and through my personal understanding.

_____ _____

Agent's Signature Date

_____ _____

First Successor Agent's Signature Date

We, serving as witnesses, each declare that the declarant signed and executed this instrument in our presence. The declarant signed it in their right state of mind, to our knowledge is eighteen years of age or older, and willingly signed without undue pressure, influence, or duress. We each sign this power of attorney as witnesses at the request of the principal while the principal is present.

_____

Witness's Signature

_____

Address

_____

Witness's Signature

_____

Address

V. Notary Acknowledgement

State of _____

County of _____

On _____, 20____ before me, _____ (name and title of officer), personally appeared _____, who proved to me on the basis of satisfactory evidence to be the person(s) whose names are subscribed within the instrument and acknowledged to me that they executed the same in their authorized capacity(ies), and that by their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of _____ that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____ (Seal)

Print Name _____