HEALTH CARE DIRECTIVE

I, _____, understand this document allows me to do one or both of the following:

PART I: Name another person (called the health care agent) to make health care decisions for me if I am unable to decide or speak for myself. My health care agent must make health care decisions for me based on the instructions I provide in this document (Part II), if any, the wishes I have made known to him or her, or must act in my best interest if I have not made my health care wishes known.

[AND/OR]

PART II: Give health care instructions to guide others making health care decisions for me. If I have named a health care agent, these instructions are to be used by the agent. These instructions may also be used by my health care providers, others assisting with my health care and my family, in the event I cannot make decisions for myself.

PART I: APPOINTMENT OF HEALTH CARE AGENT THAT IS WHO I WANT TO MAKE HEALTH CARE DECISIONS FOR ME IF I AM UNABLE TO DECIDE OR SPEAK FOR MYSELF

NOTE: If you appoint an agent, you should discuss this health care directive with your agent and give your agent a copy. If you do not wish to appoint an agent, you may leave part I blank and go to Part II.

When I am unable to decide or speak for myself, I trust and appoint _____ to make health care decisions for me. This person is called my health care agent.

Relationship of my health care agent to me is: _____

Telephone number of my health care agent is: _____

Address of my health care agent is: _____

(OPTIONAL) APPOINTMENT OF ALTERNATE HEALTH CARE AGENT: If my health care agent is not reasonably available, I trust and appoint _____ , to be my health care agent instead.

Relationship of my alternate health care agent is: _____

Address and telephone number of my alternate health care agent is:

THIS IS WHAT I WANT MY HEALTH CARE AGENT TO BE ABLE TO DO IF I AM UNABLE TO DECIDE OR SPEAK FOR MYSELF

(I know I can change these choices)

My health care agent is automatically given the powers listed below in (A) through (E). My health care agent must follow my health care instructions in this document or any other instructions I have given to my agent. If I have not given health care instructions, then my agent must act in my best interest.

Whenever I am unable to decide or speak for myself, my health care agent has the power to:

(A) Make any health care decision for me. This includes the power to give, refuse, or withdraw consent to any care, treatment, service or procedure. This includes deciding whether to stop or not start health care that is keeping me or might keep me alive, and deciding about intrusive mental health treatment.

(B) Choose my health care providers.

(C) Choose where I live and receive care and support when those choices relate to my health care needs.

(D) Review my medical records and have the same rights that I would have to give my medical records to other people.

(E) I designate the individuals appointed as my health care agents and alternate agents as my personal representatives for purposes of the health insurance portability and accountability act of 1996. My personal representatives may act on my behalf in receiving and authorizing the use and disclosure of protected health information. I waive all medical privilege in favor of any agent and personal representative I appoint under this health care directive. My agent may assert on my behalf the right to receive, review and obtain copies of my medical records and to consent to disclosure of those records.

If I do not want my health care agent to have a power listed above in (A) through (E) or if I want to limit any power in (A) through (E), I must say that here:

My health care agent is not automatically given the powers listed below in (1) and (2). If I want my agent to have any of the powers in (1) and (2), I must initial the line in front of the powers; then my agent will have that power.

____ (1) To decide whether to donate my organs when I die.
____ (2) To decide what will happen with my body when I die (burial, cremation).

If I want to say anything more about my health care agent's powers or limits on the powers, I can say it here:

PART II: HEALTH CARE INSTRUCTIONS

NOTE: Complete this Part II if you wish to give health care instructions. If you appointed an agent in Part I, completing this Part II is optional but would be very helpful to your agent. However, if you chose not to appoint an agent in Part I, you must complete some or all of this Part II if you wish to make valid health care directive.

These are instructions for my health care when I am unable to decide or speak for myself. These instructions must be followed (so long as they address my needs.)

THESE ARE MY BELIEFS AND VALUES ABOUT MY HEALTH CARE

I want you to know these things about me to help you make decisions about my health care:

My goals for my health care:

> If I am not terminally ill and there is a reasonable expectation of recovery, I wish to have such health care as will assist in my recovery and maintenance of my good health and comfort. However, if I am terminally ill and there is no reasonable expectation of recovery, I do not want care which will only serve to prolong the dying process.

My fears about my health care:

My spiritual or religious beliefs and traditions:

My beliefs about when life would be no longer worth living:

If at any time there is no reasonable expectation of my recovery from extreme physical and mental disability, I direct that I be allowed to die and not be kept alive by medication, artificial means or "heroic measures".

I particularly desire all appropriate health care in the form of medication to alleviate suffering even though this may shorten my life.

I particularly do not want any treatment that would serve only to prolong the dying process.

If I am diagnosed to have a terminal condition, I request my health providers to provide routine and medically necessary treatment if I am conscious and if my life can be extended for any significant duration.

I particularly do not want the following kinds of life-sustaining treatment if I am diagnosed to have a terminal condition and if in that terminal condition, I am not breathing or I am in the final stages, I do not wish to receive any of the following procedures:

(a) Electric or mechanical resuscitation of my heart;
(b) Nasogastric tube feeding when I am no longer able to swallow;
(c) Mechanical respiration when my brain can no longer sustain my own breathing.

I recognize that by rejecting artificially administered sustenance, then I may die of dehydration or malnutrition rather than from my illness or injury. I accept this condition if I am in a terminal condition in which there is no reasonable expectation of my recovery.

My thoughts about how my medical condition might affect my family:

THIS IS WHAT I WANT AND DO NOT WANT FOR MY HEALTH CARE

Many medical treatments may be used to try to improve my medical condition or to prolong my life. Examples include artificial breathing by a machine connected to a tube in the lungs, artificial feeding or fluids through tubes, attempts to start a stopped heart, surgeries, dialysis, antibodies, and blood transfusions. Most medical treatments can be tried for a while and then stopped if they do not help.

I have these views about my health care in these situations: (Note: You can discuss general feelings, specific treatments, or leave any of them blank).

If I had a reasonable chance of recovery, and were temporarily unable to decide or speak for myself, I would want:

> My designated agent should request such care as will assist my recovery and comfort. Such care shall include but not be limited to, care which will assist my breathing, sustenance and maintain my organs, etc., provided that the same is intended to assist in my recovery and/or comfort during recovery.

If I were dying and unable to decide or speak for myself, I would want:

> If at any time there is no reasonable expectation of my recovery from extreme physical and mental disability, I direct that I be allowed to die and not be kept alive by medication, artificial means or "heroic measures".
>
> I particularly desire all appropriate health care in the form of medication to alleviate suffering even though this may shorten my life.
>
> I particularly do not want any treatment that would serve only to prolong the dying process.
>
> If I am diagnosed to have a terminal condition, I request my health providers to provide routine and medically necessary treatment if I am conscious and if my life can be extended for any significant duration.

If I were permanently unconscious and unable to decide or speak for myself, I would want:

> My designated health care agents to oversee my care in a manner which is consistent with this document.

If I were completely dependent on others for my care and unable to decide or speak for myself, I would want:

> My health care to be provided consistent with the philosophical statements and directions contained in this document.

In all circumstances, my doctors will try to keep me comfortable and reduce my pain. This is how I feel about pain relief if it would affect my alertness or if it could shorten my life:

If I am terminally ill, I desire all appropriate health care in the form of medication to alleviate suffering even though it may shorten my life.

There are other things that I want for my health care, if possible:

Who I would like to be my doctor:

Where I would like to live to receive health care:

Where I would like to die and other wishes I have about dying:

My wishes about donating parts of my body when I die:

My wishes about what happens to my body when I die (cremation, burial):

Any other things:

PART III: MAKING THE DOCUMENT LEGAL

This document must be signed by me. It also must either be verified by a notary public (Option 1) or witnessed by two witnesses (Option 2). It must be dated when it is verified or witnessed.

I am thinking clearly, I agree with everything that is written in this document, and I have made this document willingly.

_____

Dated signed: _____
Date of Birth : _____
Address: _____
_____

If I cannot sign my name, I can ask someone to sign this document for me.

_____
(Signature of the person who I asked to sign this document for me)

_____
(Printed name of the person who I asked to sign this document for me)

Option 1 - Notary Public

In my presence on _____, 20__, _____ acknowledged his/her signature on this document or acknowledged that he/she authorized the person signing this document to sign on his/her behalf. I am not named as a health care agent or alternate health care agent in this document.

_____
Notary Public

Option 2 - Witnesses

Two witnesses must sign. Only one of the two witnesses can be a health care provider or an employee of a health care provider giving direct care to me on the day I sign this document.

Witness One:

(i) In my presence on _____, 20__, _____ acknowledged his/her signature on this document or acknowledged that he/she authorized the person signing this document to sign on his/her behalf.

(ii) I am at least 18 years of age.

(iii) I am not named as a health care agent or an alternate health care agent in this document.

(iv) If I am a health care provider or an employee of a health care provider giving direct care to the person listed above in (A), I must initial this box:____

I certify that the information on (i) through (iv) is true and correct.

_____
Witness
Address:

Witness Two:

(i) In my presence on _____, 20__, _____ acknowledged his/her signature on this document or acknowledged that he/she authorized the person signing this document to sign on his/her behalf.

(ii) I am at least 18 years of age.

(iii) I am not named as a health care agent or an alternate health care agent in this document.

(iv) If I am a health care provider or an employee of a health care provider giving direct care to the person listed above in (A), I must initial this box:____

I certify that the information on (i) through (iv) is true and correct.

_____
Witness
Address:

REMINDER: Keep this document with your personal papers in a safe place (not in a safe deposit box). Give signed copies to your doctors, family, close friends, health care agent, and alternate health care agent. Make sure your doctor is willing to follow your wishes. This document should be part of your medical record at your physician's office and at the hospital, home care agency, hospice, or nursing facility where you receive your care.

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. I authorize all health care providers, including physicians, nurses, and all other persons (including entities) who may have provided, or be providing, me with any type of health care, to disclose all of my protected health information:

(a) to an agent acting under a durable power of attorney signed by me when asked by my agent to do so for the purpose of determining my capacity as defined in the power of attorney or by governing law;

(b) to the trustee, or a designated successor trustee, of any trust of which I am a beneficiary or a trustee when asked to do so for the purpose of determining my capacity as defined in the trust;

(c) to any partner of any partnership of which I am a member for the purpose of determining my capacity as defined in the partnership agreement;

(d) to my lawyer for the purposes of determining my capacity to make inter vivos gifts, to execute estate planning documents, and whether, and to what extent, a guardianship or other protective proceedings for me is necessary or desirable; and

(e) to a guardian ad litem, if one is appointed for me, for the purpose of determining whether, and to what extent, a guardianship or other protective proceedings for me is necessary or desirable; and

(f) to a health care agent acting under a health care power of attorney or a health care directive once I am unable to decide or communicate my instructions.

2. This authorization is intended to provide my health care providers with the authorization necessary to allow each of them to disclose protected health information regarding me to the persons described in (a)-(f) above for the purpose of allowing each of them to make the specified determinations regarding my capacity or need for protective proceedings.

3. Information disclosed by a health care provider pursuant to this authorization is subject to redisclosure and may no longer be protected by the privacy rules of 45 CFR § 164.

4. This authorization may be revoked by a writing signed by me or by my personal representative.

5. This authorization shall expire five (5) years after my death unless validly revoked prior to that date.

SIGNED: _____ DATED: _____, 20__