Form must be notarized or witnessed on page 4-5 to be legal!

Advance Directive
Durable Power of Attorney for Healthcare-Living Will

For

Name _____ Date of Birth_____
Address _____
City/State/Zip: _____Phone # _____

On

Document Preparation Date: _____

Part I: Choosing a Healthcare Agent to make my medical decisions:

If something happens to me and my doctors decide I can't make my own medial decisions, this is the person I want to work with the doctors and make all my medical decisions. I trust them to make my decisions to the best of their ability based on what I have told them I want done.

The first person I choose as my power of attorney for healthcare is:

Name: _____

Phone numbers to try: _____

Address: _____

City/State/Zip: _____

Relationship to Me*:* _____

If this person can't be reached, is no longer able to help or willing to make my medical decisions, I want the following person to act in their place.
[If I chose my spouse to make my medical decisions and we are legally separated, divorced or our marriage is annulled, then the next person becomes my first agent.]

Name: _____

Phone numbers to try: _____

Address: _____

City/State/Zip: _____

Relationship to Me*:* _____

**** Other people to inform and involve in decision making if there is time may also be named-see top of page 3***

Part II: Rights and Responsibilities of my Healthcare Agent:

- They will make all medical decisions for me, subject to my desires and limitations included in this document.
- They will work with my doctors and speak for me in all things.
- If treatment has already been started, my agent may decide to have it continue, or stopped depending upon what I have told them or what they think is in my best interest.

- They have the right to look at my medical records and personal files as needed and decide who can use them.
- They can move me to another hospital, place of care or even another state if they think it best for me.
- ***Always to keep me as comfortable as possible.***

Part III-A: Statement of what I want done in an Emergency:

In the following words I have tried to give some idea of what I would want done if I am very ill. If I am being treated in a state that will not accept this as a legal document, and none of my agents can be found, I want the doctors to follow these directions as best they can, because I always have the right to decide how I am treated. ***(Please initial your choices below)***

A. <u>Emergency Care</u>: Cardiopulmonary Resuscitation (CPR) and Advanced Life Support (ALS): (CPR means pushing on my chest to keep the blood flowing. ALS may mean giving medicine, shocking the heart, and using a tube to force me to breathe.)

<u>Pick only one of the three choices!</u>

If I am not able to make my own medical decisions, I want:

___1. **(Full Code) I want** CPR and ALS tried if my heart stops or I can't breathe. **No exceptions!**

___2. **(No code/DNR/DNI*) I do not want*** CPR/ALS tried if my heart stops or I can't breathe. *[Note: If I sign consent for surgery or other treatment, this may be set aside during that surgery or treatment and recovery.]*

___3. In an emergency, I want CPR and ALS tried **unless** one or more of the following happen:
- I have an incurable illness or injury and am dying anyway, or
- I have little chance of long-term survival if my heart stops, and trying to re-start my heart or help me breathe with machines would just add to my suffering.
- In all cases life support is acceptable to me <u>only</u> if it is **short-term**. I do not want to have my life extended if there is little chance that I will return to how I was before the emergency happened.

Part III-B: Statement of what I want done at the End of My Life:

<u>End of Life Care</u>: Living Will Statement

___If I reach a point where it is seems clear to my healthcare agent that I do not know who I am, that I am not able to make my own decisions, do not know my family or friends, can't take care of myself, and unlikely to get better, ***<u>I do not want things done that will make me live longer!</u>*** I want to be kept comfortable with medication and treatment that allow me to be at peace. I understand and accept that death may come soon. (Aggressive life-sustaining treatments ***<u>I would not want if I reach this point</u>*** include tube feedings, I.V. hydration, respirator/ventilator, CPR, renal dialysis and antibiotics, etc.)

Other people I want my Healthcare Agents to include in decision making if possible are:
(Please list relationship, name and phone numbers)

_____
_____
_____
_____
_____
_____
_____

Part IV: When I am about to die:

The following are my directions at the end of my life. If my Healthcare Agent does not have the legal right to make these decisions, I ask that my family members and doctor follow these requests if possible. ***I understand that these are only my requests, but they are important to me.***

Donation of my organs or tissues:

___ I wish to donate any organ or tissue at the time of death if the donor network says I can.

___ I do not want to donate any organ or tissue a the time of death.

Autopsy:

___ I would accept an autopsy if it can help my family understand why I died, or help them with their own medical decisions or if it can help educate future doctors.

___ I do not want an autopsy.

Religion:

I am of the _____ faith, and I am active in the _____ church, congregation, synagogue, mosque or worship group. Please contact a representative of this group if I am nearing my death.

Names of persons I want my Agent(s) to inform of my healthcare condition:

_____
_____
_____

If I am nearing my death, I want: *(Where, who, what is important to me?)*

_____
_____
_____
_____

If I am nearing my death and cannot speak, I want my friends and family to know: _____

_____
_____
_____

Part V: Making This Document Legal

I am thinking clearly. I agree with everything that I have written in this document, or asked to have written for me, and I made out this form because I want to do it.

My Signature: _____

Signature Date: _____

Location of Signing:
City: _____ State:_____ Zip: _____

If I do not want to or can't sign my name, I can ask someone else to sign this form for me on the next page.

Signature of the person who I asked to sign this form for me:
_____

Print the name of the person who I asked to sign this form for me:
_____

Pick #1 or #2 to make this form legal!

#1. Notarization

On this _____ day of _____, 20_____ before me, the undersigned, a Notary Public in and for the State of _____, personally appeared:
Name of person: _____
to me known to be the person named in this document with identification verified, agreed that he/she did this as his/her voluntary act and deed.
_____
Notary Public Signature/Expiration date/Notary Stamp:

#2. Witness to the signing of this Advance Directive-Durable Power of Attorney for Healthcare-Living Will:*

The witnesses whose signatures appear below have signed the same in the presence of each other and did witness the signature of the person executing this document (or the person signing on his/her behalf and at his/her direction).
By signing below, the witnesses also each certify that he or she is not:
-A healthcare provider directly attending the person on the date of document execution;
-One of the persons named as an agent in the Durable Power of Attorney for Healthcare;
-An individual who is less than 18 years of age.
(At least one of the witnesses for a Durable Power of Attorney for Healthcare shall be an individual who is **NOT** in any way a relative of the person executing this document by blood, marriage or adoption.)*

_____
Signature of 1st Witness

_____
Print Name

_____
Street Address

_____
City State Zip

_____

Signature of 2nd Witness

_____

Print Name

_____

Street Address

_____

City State Zip

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Part VI: Permission for Release of Protected Health Information to Healthcare Agent

I give my permission to any healthcare provider and any insurance company that has provided treatment or services to me, or that has paid for or is seeking payment from me for healthcare services, to release to the **Healthcare Agent[s] named in Part I of this form**, any of my medical information regarding any past, present or future medical or mental health conditions, **including all medical information relating to each of the following conditions that I have marked with a "X" or a check mark:**

- ☐ Sexually transmitted diseases, AIDS, or HIV;
- ☐ Behavioral and mental health; and
- ☐ Alcohol, drug and other substance abuse

_____ _____

My Signature for Part VI only Today's Date

Because of the sensitive nature of these matters, the purpose of this section is to assist in deciding if the person I asked to act as my Healthcare Agent in Part I of this document should also act as my agent in these matters. **I do have the right to restrict access to this information**. This permission or restriction ends when I die, or a written request signed by me is delivered to the provider before the time information is being requested.

I understand I can end or change this permission by giving a written statement to any provider I have permitted to release information. This is statement is effective only as to those providers to whom the written termination statement is given, and only after the time of delivery.

I also understand that I have the right to inspect the disclosed information at any time. My treatment, payment, enrollment, or eligibility for benefits with any provider that I have permitted to release information is not conditioned on my signing this statement.

I know that once the information I have permitted to be released is released, it may be shared by those who receive it as they may decide to do so, and is no longer protected by the rules of HIPAA-1996.