DESIGNATION OF PATIENT ADVOCATE

(MCL 700.5506 to 700.5507)

EXPLANATION

You have the right to give instructions about your own health care. You also have the right to name someone else to make health-care decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding anatomical gifts and the designation of your primary physician. If you use this form, you may complete or modify all or any part of it.

Part 1 of this form is a Designation of Patient Advocate. Part 1 lets you name another individual as Patient Advocate to make health-care decisions for you if you become incapable of making your own decisions. You may also name an alternate Patient Advocate to act for you if your first choice is not willing, able or reasonably available to make decisions for you.

Your Patient Advocate may make all health-care decisions for you, including, absent a limitation by you, decisions concerning providing, withholding or withdrawing of a life sustaining procedure. Unless you limit the Patient Advocate 's authority, your Patient Advocate will have the right to:

(a) Consent or refuse consent to any care, treatment, service or procedure to maintain, diagnose or otherwise affect a physical or mental condition unless it's a life-sustaining procedure or otherwise required by law.

(b) Select or discharge health-care providers and health-care institutions;

(c) Consent or refuse consent to life sustaining procedures, such as, but not limited to, cardiopulmonary resuscitation and orders not to resuscitate.

(d) Direct the providing, withholding or withdrawal of artificial nutrition and hydration and all other forms of health care.

Part 2 of this form lets you give specific instructions about any aspect of your health care. Choices are provided for you to express your wishes regarding the provision, withholding or

withdrawal of treatment to keep you alive, including the provision of artificial nutrition and hydration as well as the provision of pain relief. Space is also provided for you to add to the choices you have made or for you to write out any additional instructions for other than end of life decisions.

Part 3 of this form lets you express an intention to donate your bodily organs and tissues following your death.

Part 4 of this form lets you designate a physician to have primary responsibility for your health care.

After completing this form, sign and date the form at the end. ***It is required that 2 other individuals sign as witnesses.*** A copy of the signed and completed form ***MUST BE GIVEN*** to your physician, to any other health-care providers you may have, to any health-care institution at which you are receiving care ***BEFORE THE DESIGNATION OF PATIENT ADVOCATE BECOME EFFECTIVE***. Before acting as a Patient Advocate, the proposed Patient Advocate ***MUST*** sign an acceptance of the designation.

You may revoke a Designation of Patient Advocate in any manner by which you are able to communicate your intent to revoke your Designation of Patient Advocate. If your revocation is not in writing, an individual who witnesses a revocation of a designation shall describe in writing the circumstances of the revocation, must sign the writing, and shall notify, if possible, the patient advocate of the revocation. You may also sign a new Designation of Patient Advocate form and thereby revoke the prior Designation. You may replace this form at any time.

PART 1: DESIGNATION OF PATIENT ADVOCATE

(1) DESIGNATION OF PATIENT ADVOCATE: I designate the following individual as my Patient Advocate to make health-care decisions for me only if I am unable to participate in my medical or mental treatment decisions:

____
(name of individual you choose as Patient Advocate)

____
(address)(city)(state)(zip code)

________________ ________________
(home phone) (work phone)

OPTIONAL: If I revoke my Patient Advocate's authority or if my Patient Advocate is not willing, able, or reasonably available to make a health-care decision for me, I designate as my first alternate Patient Advocate:

____
(name of individual you choose as Patient Advocate)

____
(address)(city)(state)(zip code)

________________ ________________
(home phone) (work phone)

OPTIONAL: If I revoke the authority of my Patient Advocate and first alternate Patient Advocate or if neither is willing, able, or reasonably available to make a health-care decision for me, I designate as my second alternate Patient Advocate:

____
(name of individual you choose as Patient Advocate)

____
(address)(city)(state)(zip code)

________________ ________________
(home phone) (work phone)

(2) PATIENT ADVOCATE'S AUTHORITY: My Patient Advocate is authorized to make all health-care decisions for me, except as I state here:

____

____

(Add additional sheets if necessary.)

I. INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY PHYSICAL OR MENTAL HEALTH.

A. General Grant of Power and Authority. Subject to any limitations in this Directive, my agent has the power and authority to do all of the following: (1) Request, review and receive any

information, verbal or written, regarding my physical or mental health including, but not limited to, medical and hospital records; (2) Execute on my behalf any releases or other documents that may be required in order to obtain this information; (3) Consent to the disclosure of this information; and (4) Consent to the donation of any of my organs for medical purposes. (If you want to limit the authority of your agent to receive and disclose information relating to your health, you must state the limitations in Section 2, "Patient Advocate's Authority", above.)

B. HIPAA Release Authority. My agent shall be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. 1320d and 45 CFR 160 through 164. I authorize any physician, health care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy, or other covered health care provider, any insurance company, and the Medical Information Bureau, Inc. or other health care clearinghouse that has provided treatment or services to me, or that has paid for or is seeking payment from me for such services, to give, disclose and release to my agent, without restriction, all of my individually identifiable health information and medical records regarding any past, present or future medical or mental health condition, including all information relating to the diagnosis of HIV/AIDS, sexually transmitted diseases, mental illness, and drug or alcohol abuse. The authority given my agent shall supersede any other agreement that I may have made with my health care providers to restrict access to or disclosure of my individually identifiable health information. The authority given my agent has no expiration date and shall expire only in the event that I revoke the authority in writing and deliver it to my health care provider.

(3) WHEN PATIENT ADVOCATE'S AUTHORITY BECOMES EFFECTIVE: My Patient Advocate's authority becomes effective when my primary physician determines I lack the capacity to make my own health-care decisions. As to decisions concerning the providing, withholding and withdrawal of life-sustaining procedures my Patient Advocate's authority becomes effective when my primary physician determines I lack the capacity to make my own health-care decisions and my primary physician and another physician determine I am in a terminal condition or permanently unconscious.

(4) PATIENT ADVOCATE'S OBLIGATION: My Patient Advocate shall make health-care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my Patient Advocate. To the extent my wishes are unknown, my Patient Advocate shall make health-care decisions for me in accordance with what my Patient Advocate determines to be in my best interest. In determining my best interest, my Patient Advocate shall consider my personal values to the extent known to my Patient Advocate.

(5) NOMINATION OF GUARDIAN: If a guardian of my person needs to be appointed for me by a court, (please check one):

☐ I nominate the Patient Advocate(s) whom I named in this form in the order designated to act as guardian.

☐ I nominate the following to be guardian in the order designated:

______ ____

______ ____

______ ____

☐ I do not nominate anyone to be guardian.

PART 2: INSTRUCTIONS FOR HEALTH CARE

If you are satisfied to allow your Patient Advocate to determine what is best for you in making end-of-life decisions, you need not fill out this part of the form. If you do fill out this part of the form, you may strike any wording you do not want.

(6) END-OF-LIFE DECISIONS: I direct that my health-care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below:

Choice Not To Prolong Life

I do not want my life to be prolonged if: (please check all that apply)

☐ (i) I have a terminal condition (an incurable condition caused by injury, disease, or illness which, to a reasonable degree of medical certainty, makes death imminent and from which, despite the application of life-sustaining procedures, there can be no recovery)

and

regarding artificial nutrition and hydration, I make the following specific directions:

	I want used	I do not want used
Artificial nutrition through a conduit	☐	☐
Hydration through a conduit	☐	☐

☐ (ii) I become permanently unconscious (a medical condition that has been diagnosed in accordance with currently accepted medical standards that has lasted at least 4 weeks and with reasonable medical certainty as total and irreversible loss of consciousness and capacity for interaction with the environment. The term includes, without limitation, a persistent vegetative state or irreversible coma)

and

regarding artificial nutrition and hydration, I make the following specific directions:

	I want used	I do not want used
Artificial nutrition through a conduit	☐	☐
Hydration through a conduit	☐	☐

Choice To Prolong Life

☐ I want my life to be prolonged as long as possible within the limits of generally accepted health-care standards.

RELIEF FROM PAIN: Except as I state in the following space, I direct treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death:

____

____

(7) OTHER MEDICAL INSTRUCTIONS: (If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:

____

____

(Add additional sheets if necessary.)

PART 3: ANATOMICAL GIFTS AT DEATH

(OPTIONAL)

(8) I am mentally competent and 18 years or more of age.

I hereby make this anatomical gift to take effect upon my death. My patient advocate's authority to make an anatomical remains exercisable after my death.
The marks in the appropriate squares and words filled into the blanks below indicate my desires.

I give:

☐ my body;

☐ my needed organs or parts;

☐ the following organs or parts;

____

____

To the following person or institutions

☐ the physician in attendance at my death;

☐ the hospital in which I die;

☐ the following named physician, hospital, storage bank or other medical institution; ______

____

☐ the following individual for treatment; ______

____

for the following purposes:

☐ any purpose authorized by law;

☐ transplantation;

☐ therapy;

☐ research;

☐ medical education.

PART 4: PRIMARY PHYSICIAN

(OPTIONAL)

(9) I designate the following physician as my primary physician:

____

(name of physician)

____

(address)(city)(state)(zip code)

____

(phone)

OPTIONAL: If the physician I have designated above is not willing, able or reasonably available to act as my primary physician, I designate the following physician as my alternate primary physician:

____

(name of physician)

____

(address)(city)(state)(zip code)

____

(phone)

Primary Physician shall mean a physician designated by an individual or the individual's Patient Advocate or guardian, to have primary responsibility for the individual's health care or, in the absence of a designation or if the designated physician is not reasonably available, a physician who undertakes the responsibility.

(10) **EFFECT OF COPY:** A copy of this form has the same effect as the original.

(11) **SIGNATURE:** Sign and date the form here:

I understand the purpose and effect of this document.

Date:_____________________________

Sign Your Name: ____

Print Your Name: ____

____

(address)(city)(state)(zip code)

(12) SIGNATURES OF WITNESSES:

Statement Of Witnesses

SIGNED AND DECLARED by the above-named declarant as and for his/her written Designation of Patient Advocate pursuant to the Michigan Consolidated Laws, 700.5506 *et seq.***,** who in his/her presence, at his/her request, and in the presence of each other, have hereunto subscribed our names as witnesses, and state and affirm:

That the Principal appeared to be at least eighteen years of age, of sound mind and under no constraint or undue influence. Further, neither witness is the patient's spouse, parent, child, grandchild, sibling, presumptive heir, known devisee at the time of the witnessing, physician, or patient advocate or an employee of a life or health insurance provider for the patient, of a health facility that is treating the patient, or of a home for the aged as defined in section 20106 of the public health code, 1978 PA 368, MCL 333.20106, where the patient resides. Neither witness is

named as a Patient Advocate or an Alternate Patient Advocate in this Designation of Patient Advocate.

First witness:

____
(print name)

____
(address)(city, state, zip code)

____
(signature of witness) (date)

Second witness:

____
(print name)

____
(address)(city, state, zip code)

____
(signature of witness) (date)

Acceptance by Agent

I, ____, being fully advised in the premises, do hereby accept appointment as the Patient Advocate for ____ (the Patient).

I understand and accept the following terms and conditions of this appointment:

(1) A patient advocate designation may include a statement of the patient's desires on care, custody, and medical treatment or mental health treatment, or both. A patient advocate designation may also include a statement of the patient's desires on the making of an anatomical gift of all or part of the patient's body under part 101 of the public health code, 1978 PA 368, MCL 333.10101 to 333.10109. The patient may authorize the patient advocate to exercise 1 or more powers concerning the patient's care, custody, medical treatment, mental health treatment, or the making of an anatomical gift that the patient could have exercised on his or her own behalf.

(2) A patient may designate in the patient advocate designation a successor individual as a patient advocate who may exercise powers concerning care, custody, and medical or mental health treatment decisions or concerning the making of an anatomical gift for the patient if the first individual named as patient advocate does not accept, is incapacitated, resigns, or is removed.

(3) Before a patient advocate designation is implemented, a copy of the patient advocate designation must be given to the proposed patient advocate and must be given to a successor patient advocate before the successor acts as patient advocate. Before acting as a patient advocate, the proposed patient advocate must sign an acceptance of the patient advocate designation.

(4) The acceptance of a designation as a patient advocate must include substantially all of the following statements:

1. This patient advocate designation is not effective unless the patient is unable to participate in decisions regarding the patient's medical or mental health, as applicable. If this patient advocate designation includes the authority to make an anatomical gift as described in section 5506, the authority remains exercisable after the patient's death.

2. A patient advocate shall not exercise powers concerning the patient's care, custody, and medical or mental health treatment that the patient, if the patient were able to participate in the decision, could not have exercised on his or her own behalf.

3. This patient advocate designation cannot be used to make a medical treatment decision to withhold or withdraw treatment from a patient who is pregnant that would result in the pregnant patient's death.

4. A patient advocate may make a decision to withhold or withdraw treatment that would allow a patient to die only if the patient has expressed in a clear and convincing manner that the patient advocate is authorized to make such a decision, and that the patient acknowledges that such a decision could or would allow the patient's death.

5. A patient advocate shall not receive compensation for the performance of his or her authority, rights, and responsibilities, but a patient advocate may be reimbursed for actual and necessary expenses incurred in the performance of his or her authority, rights, and responsibilities.

6. A patient advocate shall act in accordance with the standards of care applicable to fiduciaries when acting for the patient and shall act consistent with the patient's best interests. The known desires of the patient expressed or evidenced while the patient is able to participate in medical or mental health treatment decisions are presumed to be in the patient's best interests.

7. A patient may revoke his or her patient advocate designation at any time and in any manner sufficient to communicate an intent to revoke.

8. A patient may waive his or her right to revoke the patient advocate designation as to the power to make mental health treatment decisions, and if such a waiver is made, his or her ability to revoke as to certain treatment will be delayed for 30 days after the patient communicates his or her intent to revoke.

9. A patient advocate may revoke his or her acceptance of the patient advocate designation at any time and in any manner sufficient to communicate an intent to revoke.

10. A patient admitted to a health facility or agency has the rights enumerated in section 20201 of the public health code, 1978 PA 368, MCL 333.20201.

DATED, this the _____ day of ______________________, 20_____.

____

____

Patient Advocate

DATED, this the _____ day of ______________________, 20_____.

____

First Alternate Patient Advocate

DATED, this the _____ day of ______________________, 20_____.

____

Second Alternate Patient Advocate