Notes: This file contains a Health Care Declaration for Pennsylvania (commonly called a "Living Will"), and a Durable Power of Attorney for Health Care.

DECLARATION

I, _____, being of sound mind, willfully and voluntarily make this declaration to be followed if I become incompetent. This declaration reflects my firm and settled commitment to refuse life-sustaining treatment under the circumstances indicated below. I direct my attending physician to withhold or withdraw life-sustaining treatment that serves only to prolong the process of my dying, if I should be in a terminal condition or in a state of permanent unconsciousness.

I direct that treatment be limited to measures to keep me comfortable and to relieve pain, including any pain that might occur by withholding or withdrawing life-sustaining treatment.

In addition, if I am in the condition described above, I feel especially strong about the following forms of treatment:

I (____) do (____) do not want cardiac resuscitation.
I (____) do (____) do not want mechanical respiration.
I (____) do (____) do not want tube feeding or any other artificial or invasive form of nutrition (food) or hydration (water).
I (____) do (____) do not want blood or blood products.
I (____) do (____) do not want any form of surgery or invasive diagnostic tests.
I (____) do (____) do not want kidney dialysis.
I (____) do (____) do not want antibiotics.

I realize that if I do not specifically indicate my preference regarding any of the forms of treatment listed above, I may receive that form of treatment.

Other instructions:

I (____) do (____) do not want to designate another person as my surrogate to make medical treatment decisions for me if I should be incompetent and in a terminal condition or in a state of permanent unconsciousness. Name and address of surrogate (if applicable):

_____
_____
_____

Name and address of substitute surrogate (if surrogate above is unable to serve):

_____
_____
_____

I (____) do (____) do not want to make an anatomical gift of all or part of my body, subject to the following limitations, if any:

_____
_____

I made this declaration on the _____ day of _____, 20_____.

_____
Declarant's signature

_____
_____
Declarant's address

The declarant or the person on behalf of and at the direction of declarant knowingly and voluntarily signed this writing by signature or mark in my presence.

Witness's signature: _____
Witness's address: _____
_____

Witness's signature: _____
Witness's address: _____
_____

Source: PA Statutes title 20, Chapter 54

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

THIS IS AN IMPORTANT LEGAL DOCUMENT. BEFORE SIGNING THIS DOCUMENT YOU SHOULD KNOW THESE IMPORTANT FACTS:

Except to the extent you state otherwise, this document gives the person you name as your agent the authority to make any and all health care decisions for you when you are no longer capable of making them yourself. "Health care" means any treatment, service or procedure to maintain, diagnose or treat your physical or mental condition. Your agent, therefore, can have the power to make a broad range of health care decisions for you. Your agent may consent, refuse to consent, or withdraw consent to medical treatment and may make decisions about withdrawing or withholding life-sustaining treatment. Your agent cannot consent or direct any of the following: commitment to a state institution, sterilization, or termination of treatment if you are pregnant and if the withdrawal of that treatment is deemed likely to terminate the pregnancy unless the failure to withhold the treatment will be physically harmful to you or prolong severe pain which cannot be alleviated by medication.

You may state in this document any treatment you do not desire, except as stated above, or treatment you want to be sure you receive. Your agent's authority will begin when your doctor certifies that you lack the capacity to make health care decisions. If for moral or religious reasons you do not wish to be treated by a doctor or examined by a doctor for the certification that you lack capacity, you must say so in the document and name a person to be able to certify your lack of capacity. That person may not be your agent or alternate agent or any person ineligible to be your agent. You may attach additional pages if you need more space to complete your statement.

If you want to give your agent authority to withhold or withdraw the artificial providing of nutrition and fluids, your document must say so. Otherwise, your agent will not be able to direct that. Under no conditions will your agent be able to direct the withholding of food and drink for you to eat and drink normally.

Your agent will be obligated to follow your instructions when making decisions on your behalf. Unless you state otherwise, your agent will have the same authority to make decisions about your health care as you would have had if made consistent with state law.

It is important that you discuss this document with your physician or other health care providers before you sign it to make sure that you understand the nature and range of decisions which may be made on your behalf. If you do not have a physician, you should talk with someone else who is knowledgeable about these issues and can answer your questions. You do not need a lawyer's assistance to complete this document, but if there is anything in this document that you do not understand, you should ask a lawyer to explain it to you.

The person you appoint as agent should be someone you know and trust and must be at least 18 years old. If you appoint your health or residential care provider (e.g. your physician, or an employee of a home health agency, hospital, nursing home, or residential care home, other than a relative), that person will have to choose between acting as your agent or as your health or residential care provider; the law does not permit a person to do both at the same time.

You should inform the person you appoint that you want him or her to be your health care agent. You should discuss this document with your agent and your physician and give each a signed copy. You should indicate on the document itself the people and institutions who will have signed copies. Your agent will not be liable for health care decisions made in good faith on your behalf.

Even after you have signed this document, you have the right to make health care decisions for yourself as long as you are able to do so, and treatment cannot be given to you or stopped over your objection. You have the right to revoke the authority granted to your agent by informing him or her or your health care provider orally or in writing.

This document may not be changed or modified. If you want to make changes in the document you must make an entirely new one.

You should consider designating an alternate agent in the event that your agent is unwilling, unable, unavailable, or ineligible to act as your agent. Any alternate agent you designate will have the same authority to make health care decisions for you.

1. DESIGNATION OF HEALTH CARE AGENT.

I, _____, (Insert your name and address) do hereby designate and appoint

_____

(Insert name, address, and telephone number of one individual only as your agent to make health care decisions for you. None of the following may be designated as your agent: (1) your treating health care provider, (2) a nonrelative employee of your treating health care provider, (3) an operator of a community care facility, or (4) a nonrelative employee of an operator of a community care facility).

as my attorney in fact (agent) to make health care decisions for me as authorized in this document. For the purposes of this document, "health care decision" means consent, refusal of consent, or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose, or treat an individual's physical condition.

2. CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE. By this document I intend to create a durable power of attorney for health care. This power of attorney shall not be affected by my subsequent incapacity.

3. GENERAL STATEMENT OF AUTHORITY GRANTED. Subject to any limitations in this document, I hereby grant to my agent full power and authority to make health care decisions for me to the same extent that I could make such decisions for myself if I had the capacity to do so. In exercising this authority, my agent shall make health care decisions that are consistent with my desires as stated in this document or otherwise made known to my agent, including, but not limited to, my desires concerning obtaining or refusing or withdrawing life-prolonging care, treatment, services, and procedures.

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.

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. *(If you want to limit the authority of your agent to make health care decisions for you, you can state the limitations in paragraph 4 ("Statement of Desires, Special Provisions, and Limitations") below. You can indicate your desires by including a statement of your desires in the same paragraph.)*

4. STATEMENT OF DESIRES, SPECIAL PROVISIONS, AND LIMITATIONS. *(Your agent must make health care decisions that are consistent with your known desires. You can, but are not required to, state your desires in the space provided below. You should consider whether you want to include a statement of your desires concerning life-prolonging care, treatment, services, and procedures. You can also include a statement of your desires concerning other matters relating to your health care. You can also make your desires known to your agent by discussing your desires with your agent or by some other means. If there are any types of treatment that you do not want to be used, you should state them in the space below. If you want to limit in any other way the authority given your agent by this document, you should state the limits in the space below. If you do not state any limits, your agent will have broad powers to make health care decisions for you, except to the extent that there are limits provided by law.)*

In exercising the authority under this durable power of attorney for health care, my agent shall act consistently with my desires as stated. Additional statement of desires, special provisions, and limitations:

[None or State limitations]

_____

_____

(You may attach additional pages if you need more space to complete your statement. If you attach additional pages, you must date and sign each of the additional pages at the same time you date and sign this document.)

5. INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY PHYSICAL OR MENTAL HEALTH. Subject to any limitations in this document, my agent has the power and authority to do all of the following:

(a) Request, review, and receive any information, verbal or written, regarding my physical or mental health, including, but not limited to, medical and hospital records.

(b) Execute on my behalf any releases or other documents that may be required in order to obtain this information.

(c) Consent to the disclosure of this information.

(d) 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 paragraph 4 ("Statement of Desires, Special Provisions, and Limitations") above.)*

6. SIGNING DOCUMENTS, WAIVERS, AND RELEASES. Where necessary to implement the health care decisions that my agent is authorized by this document to make, my agent has the power and authority to execute on my behalf all of the following:

(a) Documents titled or purporting to be a "Refusal to Permit Treatment" and "Leaving Hospital Against Medical Advice."

(b) Any necessary waiver or release from liability required by a hospital or physician.

7. DESIGNATION OF ALTERNATE AGENTS.
(You are not required to designate any alternate agents but you may do so. Any alternate agent you designate will be able to make the same health care decisions as the agent you designated in paragraph 1, above, in the event that agent is unable or ineligible to act as your agent. If the agent you designated is your spouse, he or she becomes ineligible to act as your agent if your marriage is dissolved.)

If the person designated as my agent in paragraph 1 is not available or becomes ineligible to act as my agent to make a health care decision for me or loses the mental capacity to make health care decisions for me, or if I revoke that person's appointment or authority to act as my agent to make health care decisions for me, then I designate and appoint the following persons to serve as my agent to make health care decisions for me as authorized in this document, such persons to serve in the order listed below:

A. First Alternate Agent

_____

(Insert name, address, and telephone number of first alternate agent)

B. Second Alternate Agent

_____

(Insert name, address, and telephone number of second alternate agent)

8. PRIOR DESIGNATIONS REVOKED. I revoke any prior durable power of attorney for health care.

DATE AND SIGNATURE OF PRINCIPAL
(You Must Date and Sign This Power of Attorney)

I sign my name to this Statutory Form Durable Power of Attorney for Health Care on _____ at _____,
(Date) (City) (State)

_____
(You sign here)

(This Power of Attorney will not be valid unless it is signed by two qualified witnesses who are present when you sign or acknowledge your signature. If you have attached any additional pages to this form, you must date and sign each of the additional pages at the same time you date and sign this Power of Attorney.)

STATEMENT OF WITNESSES

(This document must be witnessed by two qualified adult witnesses. None of the following may be used as a witness: (1) a person you designate as your agent or alternate agent, (2) a health care provider, (3) an employee of a health care provider, (4) the operator of a community care facility, (5) an employee of an operator of a community care facility, (6) your spouse, or (7) your lawful heirs or beneficiaries named in your will or a deed. At least one of the witnesses must make the additional declaration set out following the place where the witnesses sign.)

I declare under penalty of perjury under the laws of _____ that the person who signed or acknowledged this document is personally known to me (or proved to me

on the basis of convincing evidence) to be the principal, that the principal signed or acknowledged this durable power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, that I am not the person appointed as attorney in fact by this document, and that I am not a health care provider, an employee of a health care provider, the operator of a community care facility, an employee of an operator of a community care facility, my spouse, or my lawful heirs or beneficiaries named in a Will or deed.

Signature: _____ Residence address: _____
Print name: _____ _____
Date: _____

Signature: _____ Residence address: _____
Print name: _____ _____
Date: _____

(At least one of the above witnesses must also sign) I further declare under penalty of perjury under the laws of _____ that I am not related to the principal by blood, marriage, or adoption, and, to the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

Signature: _____
Signature: _____

I, _____, have read the attached power of attorney and am the person identified as the agent for the principal. I hereby acknowledge that in the absence of a specific provision to the contrary in the power of attorney or in 20 Pa.C.S. when I act as agent:

I shall exercise the powers for the benefit of the principal.

I shall keep the assets of the principal separate from my assets.

I shall exercise reasonable caution and prudence.

I shall keep a full and accurate record of all actions, receipts and disbursements on behalf of the principal.

_____ _____
Agent Date

NOTARY

(Notary is also recommended.)

State of _____
County of _____ ss.

On this ____ day of _____ 20____ before me personally appeared _____ full name of signer of instrument) to me known (or proved to me on basis of satisfactory evidence) to be the person whose name is subscribed to this instrument, and acknowledged that he/she executed it. I declare under penalty of perjury that the person whose name is subscribed to this instrument appears to be of sound mind and under no duress, fraud or undue influence.

_____
Notary

_____
Print Name of Notary

My Commission Expires:
_____