VERMONT ADVANCE DIRECTIVE FOR HEALTH CARE

Pursuant to 18 V.S.A. 9703

Name _____

Date of Birth _____
Address _____
_____

Part One: Appointment of My Health Care Agent

I appoint _____
Address _____
_____

Telephone _____ Mobile phone _____ E-mail _____

as my Health Care **Agent** to make any and all health care decisions for me, except to the extent that I state otherwise in this document.

If this health care agent is unavailable, unwilling or unable to do this for me, I appoint _____ to be my **Alternate Agent**.

Address: _____
_____

Telephone _____ Mobile phone _____ E-mail _____

Others who can be consulted about medical decisions on my behalf include:
_____
_____

Those who should NOT be consulted include:
_____

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.

(Optional space below is to identify your doctor or health care provider:) *Your doctor cannot also serve as your health care agent.

Primary care physician _____
Address _____
Office Telephone:_____

Part Two: Treatment Wishes

Please express your preferences that follow by checking or initialing the statements. **You may check or initial more than one choice.** If you do nothing, your agent or others such as family members and doctors treating you will assume you want them to decide for you. **If you do not state a preference for withholding or withdrawing artificial food (tube feeding) and hydration, your agent may not have authority to withhold or withdraw it, without a court order, if you are being treated in a New York or New Hampshire hospital.**

_____ **A. <u>My Choice is to Limit Treatment</u>** - I do not want to be kept alive if:

(*Initial those statements below that you agree with)*

_____ **1.** I am so sick that I will die within a relatively short time (I cannot get better and have only weeks, days or hours left to live),

_____ **2.** I become unconscious or unaware of my surroundings and most doctors agree that I will never regain consciousness,

_____ **3.** I become unable to think or act for myself (and won't get better), or

_____ **4.** The likely risks and burdens of treatment would outweigh the expected benefits. (For example: I will be in pain, or I will be unable to do things for myself, or the costs of caring for me will be beyond my willingness to pay.)

_____ **5.** If it is possible that I might recover with treatment and more time is needed to determine if I can get better or not, I wish my medical team to start the necessary treatments to keep me alive. If, over time, these treatments do not improve my chances of living or my physical condition, I wish to have life-sustaining treatment stopped.

_____ **6**. If I have initialed or checked any of the situations above and am also unable to swallow enough food and water to stay alive, I **do** want food and water to be given to me by vein or by feeding tube.

_____ **7**. If I have initialed or checked situations 1-5, I ***do <u>not</u>*** want food and water to be given to me by vein or feeding tube, but I will accept medication for pain and agitation through an intravenous line.

_____ **8.** Other specific instructions are as follows:

_____**B. <u>My Choice is to Sustain Life</u>** - I want to be kept alive as long as possible through any means possible regardless of my condition or awareness.

_____ **C. Specific Care Wishes Near the End of My Life**

_____ If it becomes clear to my doctor, my agent and those caring for me that I am dying, I want palliative care for my pain, worries, nausea and other conditions that bother me. I want sufficient ***pain medication*** even though it may hasten my death.

_____ I want ***hospice care*** when I am dying, if possible and appropriate.

_____ I prefer to ***die at home***, if this is possible.

_____ **D. Spiritual and Other Care Concerns:**

I am of the _____ faith. Below is the contact information (if known).

Church, Synagogue or Worship Center: _____
Address:_____ Leader
_____ phone # _____

Other people to notify if I have a life-threatening illness:
_____
_____
_____

Part Three: Specific Instructions about ORGAN DONATION

I want my agent (if I have appointed one), family, friends and all who care about me to follow my wishes about organ donation if that is an option at the time of my death. (Initial below all that apply.)

_____ I do **not** wish to be an organ donor.

_____ I wish to donate the following organs and tissues:
- _____ any needed organs or tissues
- _____ major organs (heart, lungs, kidneys, etc.)
- _____ tissues such as skin and bones
- _____ eye tissue such as corneas

_____ I desire to donate my body to research or educational programs. (Note: you will have to make your own arrangements through a Medical School or other program.)

It is very important that you talk with your family and your health care agent about your wishes regarding organ donation.

_____ If an **autopsy** is suggested for any reason, I give my permission to have it done.

Part Four: Desires for Disposition of my Remains after Death

1. The person I want to serve as my agent for disposition of my body is _____

a. _____ I want my health care agent to decide arrangements after my death.
_____ If he or she is not available, I want my alternate agent to decide.

b. _____ Regardless of my appointment of a health care agent above, I appoint the following person to decide about and arrange for the disposition of my body after my death.

_____
Address: _____
Telephone: _____

(OR)

c. _____ I want my family to decide.

II. My preference for burial and disposition of my remains after death.

a. _____ I want a funeral followed by burial in a casket at the following location, if possible: _____

b. _____ I want to be cremated and have my ashes buried or distributed as follows: _____

c. _____ I want to have arrangements made at the direction of my agent or family.

I have a pre-need contract for funeral arrangements with the following funeral service: _____

Part Five: Signed Declaration of Wishes

Signed _____ Date _____

The witnesses below affirm that the principal appeared to understand the nature of the document and to be free from duress or undue influence.

Your agent, spouse, reciprocal beneficiary, parent, adult sibling, adult child or adult grandchild may NOT be a witness. Appointed agents, family members, heirs, health care providers, funeral service staff and anyone to whom you owe money may *not* be witnesses.

Witness Signature _____
(Printed Name)_____
Address _____

Witness Signature _____
(Printed Name)_____
Address _____

If the maker is a current patient or resident in a hospital, nursing home or residential care home, the following *additional witness* confirms the maker's capacity, understanding, and freedom from undue influence (Hospital Explainer or Long-term-care Ombudsman or clergy, attorney, probate court designee):

Name _____
Address _____
_____
Title/position _____ Date _____