ADVANCE HEALTHCARE DIRECTIVE AND DURABLE POWER OF ATTORNEY FOR HEALTHCARE

I, _____, residing at _____, City of _____, State of _____, Zip Code _____, being of sound mind and eighteen (18) years of age or older, declare this to be my Advance Healthcare Directive and Durable Power of Attorney for Healthcare. This document reflects my wishes regarding my healthcare and designates an agent to make healthcare decisions for me if I am unable to do so. I intend for this document to be legally binding and effective immediately upon my signing, and to remain effective even if I become incapacitated.

I. DESIGNATION OF HEALTHCARE AGENT

I designate the following person as my Healthcare Agent to make any and all healthcare decisions for me, including decisions regarding medical treatment, care, and services, whenever I am unable to make those decisions for myself. My Agent's authority shall be effective upon my attending physician determining that I lack the capacity to make my own healthcare decisions.

A. Primary Healthcare Agent:

Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone (Home): _____ Phone (Cell): _____

Email: _____

B. Successor Healthcare Agent(s) (Optional):

If my Primary Healthcare Agent is unwilling, unable, or unavailable to act, I designate the following person(s) as my Successor Healthcare Agent(s), in the order named: First Successor Healthcare Agent:

Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone (Home): _____ Phone (Cell): _____

Email: _____

Second Successor Healthcare Agent:

Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone (Home): _____ Phone (Cell): _____

Email: _____

II. AUTHORITY OF HEALTHCARE AGENT

My Healthcare Agent shall have the full power and authority to make any and all healthcare decisions for me, including the power to: 1. Consent to, refuse, or withdraw consent for any medical treatment, service, or procedure, including diagnostic tests, medication, surgery, and hospital care.
2. Select or discharge healthcare providers and institutions.
3. Request, review, and receive any information, verbal or written, regarding my physical or mental health, including medical and hospital records, and to execute any releases or other documents that may be required to obtain such information. This authorization is intended to comply with the Health Insurance Portability and Accountability Act (HIPAA) and all other applicable federal and state laws.
4. Authorize my admission to or discharge from any hospital, nursing home, residential care facility, or other healthcare institution.
5. Make decisions regarding the provision or withdrawal of life-sustaining treatment, as further specified in Section III below.
6. Make arrangements for my care and comfort, including pain management.
7. Consent to or refuse the administration of pain-relieving drugs, even if such drugs may shorten my life.
8. Make decisions regarding organ and tissue donation, as further specified in Section IV below.
9. Take any other action necessary to carry out my healthcare wishes.

My Healthcare Agent is authorized to act on my behalf as if I were personally present and acting. My Agent's decisions shall be binding on all persons, including healthcare providers and institutions.

III. INSTRUCTIONS FOR HEALTHCARE

My Healthcare Agent shall make healthcare decisions for me consistent with my desires as expressed in this document or otherwise known to my Agent. If my desires are unknown, my Agent shall make decisions in my best interest, considering my personal values.

A. When Agent's Authority Begins:

My Agent's authority to make healthcare decisions for me shall begin when my attending physician determines that I lack the capacity to make my own healthcare decisions.

B. Life-Sustaining Treatment:

Life-sustaining treatment includes any medical procedure, medication, or device that would serve only to prolong the dying process or to maintain me in a state of permanent unconsciousness. This includes, but is not limited to, artificial nutrition and hydration, cardiopulmonary resuscitation (CPR), mechanical ventilation, and dialysis.

Please indicate my wishes regarding life-sustaining treatment by checking the appropriate box(es) below. If no box is checked, my Agent shall make decisions based on my best interests and known values.

1. **If I am in a terminal condition** (an incurable and irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of my attending physician, result in death within a relatively short period of time):

☐ I want to receive all available life-sustaining treatment necessary to prolong my life as long as possible.

☐ I do not want life-sustaining treatment to be initiated or continued if it would only prolong the dying process. I want to be kept comfortable and receive pain medication, even if it shortens my life.

☐ My Agent should make decisions regarding life-sustaining treatment based on my best interests and known values.

2. **If I am in a permanently unconscious state** (a persistent vegetative state or irreversible coma, as determined by my attending physician in accordance with accepted medical standards):

☐ I want to receive all available life-sustaining treatment.

☐ I do not want life-sustaining treatment to be initiated or continued. I want to be kept comfortable and receive pain medication, even if it shortens my life.

☐ My Agent should make decisions regarding life-sustaining treatment based on my best interests and known values.

3. **If I have an end-stage condition** (a severe, chronic, and irreversible disease, illness, or injury that has progressed to a point where it is unlikely to improve, and that, in the opinion of my attending physician, will result in death within a relatively short period of time, even with the administration of life-sustaining treatment):

☐ I want to receive all available life-sustaining treatment necessary to prolong my life as long as possible.

☐ I do not want life-sustaining treatment to be initiated or continued if it would only prolong the

dying process. I want to be kept comfortable and receive pain medication, even if it shortens my life.

☐ My Agent should make decisions regarding life-sustaining treatment based on my best interests and known values.

C. Pain Relief:

I direct that my comfort be a priority. I wish to receive medication and other measures to alleviate pain, even if this may indirectly hasten my death.

D. Other Instructions:

My additional instructions or preferences regarding my healthcare are:

_____

_____

_____

_____

IV. ORGAN AND TISSUE DONATION

Upon my death, I wish to make the following anatomical gift: ☐ I consent to donate any needed organs, tissues, and eyes.

☐ I consent to donate only the following organs, tissues, or eyes: _____

☐ I do not consent to organ, tissue, or eye donation.

My decision regarding organ and tissue donation is subject to the Uniform Anatomical Gift Act, as adopted in the state where this document is executed.

V. NOMINATION OF GUARDIAN (OPTIONAL)

If a court should determine that it is necessary to appoint a guardian or conservator of my person, I nominate my Healthcare Agent named above, in the order designated, to serve in that capacity.

VI. REVOCATION

I hereby revoke any prior Durable Power of Attorney for Healthcare, Advance Healthcare Directive, Living Will, or similar document I may have executed.

VII. MISCELLANEOUS PROVISIONS

A. Severability: If any provision of this document is held to be invalid, such invalidity shall not affect other provisions of this document which can be given effect without the invalid provision, and to this end, the provisions of this document are declared to be severable.

B. Governing Law: This document shall be governed by and construed in accordance with the laws of the state where this document is executed.

C. Copies: A copy of this document shall have the same force and effect as the original.

I understand the purpose and effect of this document. I am emotionally and mentally competent to make this Advance Healthcare Directive and Durable Power of Attorney for Healthcare. I sign this document voluntarily and without coercion.

Signed this _____ day of _____, 20_____.

DECLARANT

Signature: _____
Print Name: _____
Date: _____ day of _____, 20_____
Address: _____

WITNESS ATTESTATION

I declare that the person who signed or acknowledged this document (the Declarant) is personally known to me, that the Declarant signed or acknowledged this document in my presence, that the Declarant appears to be of sound mind and under no duress, fraud, or undue influence, and that I am not the person appointed as Healthcare Agent or Successor Healthcare Agent in this document. I am not a healthcare provider or an employee of a healthcare provider or facility. I am not an heir or beneficiary of the Declarant.

Witness 1:

Signature: _____
Print Name: _____
Date: _____ day of _____, 20_____
Address: _____

Witness 2:

Signature: _____

Print Name: _____

Date: _____ day of _____, 20_____

Address: _____

NOTARY ACKNOWLEDGMENT

State of _____

County of _____

On this _____ day of _____, 20_____, before me, a Notary Public in and for said County and State, personally appeared _____ (Declarant's Name), known to me (or satisfactorily proven) to be the person whose name is subscribed to the foregoing instrument, and acknowledged that he/she executed the same for the purposes therein contained.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal.

Notary Public: _____

Print Name: _____

My Commission Expires: _____