Advance Health Care Directive

PRINCIPAL INFORMATION

Full Legal Name of Principal: [Your full legal name]

Complete Address of Principal: [Complete address]

I, [Your full legal name], residing at [Complete address], being of sound mind and acting voluntarily, hereby establish this Advance Health Care Directive.

REVOCATION OF PRIOR DIRECTIVES

I hereby revoke and cancel any and all previous Advance Health Care Directives that I may have executed prior to this date.

DESIGNATION OF PRIMARY HEALTH CARE AGENT

In the circumstance that I am determined to lack the capacity to provide informed consent for medical, surgical, and diagnostic procedures, I hereby designate the following individual to serve as my primary health care agent for all health care decisions:

Full Name of Primary Health Care Agent: [Primary agent full name]

Complete Address: [Primary agent complete address]

Phone Number: [Primary agent phone number]

Email Address: [Primary agent email address]

DESIGNATION OF ALTERNATE HEALTH CARE AGENT

Should my designated primary health care agent be unwilling, unable, or unavailable to fulfill the role of my health care agent, I hereby appoint the following individual as my alternate health care agent:

Full Name of Alternate Health Care Agent: [Alternate agent full name]

Complete Address: [Alternate agent complete address]

Phone Number: [Alternate agent phone number]

Email Address: [Alternate agent email address]

POWERS AND AUTHORITY OF HEALTH CARE AGENT

My designated health care agent is granted the authority to make any and all health care decisions on my behalf, except where I have specifically stated otherwise in this document. Both my primary health care agent and any alternate health care agent shall possess full authority to make all decisions concerning my medical care, treatment, or procedures necessary to maintain, diagnose, or treat any physical or mental health condition, as well as decisions regarding my personal care.

In the event that either (1) I develop an incurable or irreversible medical condition that will result in my death within a reasonably short period of time and I am no longer capable of providing informed consent regarding my medical treatment, or (2) I enter into a permanent state of unconsciousness such as a coma or persistent vegetative state, my health care agent and any alternate health care agent shall additionally have the authority to make decisions regarding the provision, withholding, or withdrawal of life-sustaining treatments on my behalf.

My health care agent is granted complete authority to review and obtain any information pertaining to my physical or mental health status, including but not limited to medical records and hospital records, in accordance with the Health Insurance Portability and Accountability Act of 1996, 42 USC 1320d ("HIPAA") and the American Recovery and Reinvestment Act of 2009 ("ARRA").

My health care agent's authority is strictly limited to matters concerning my health care and does not extend to any other purposes. All actions taken by my health care agent pursuant to this authority shall have the same legal effect upon my heirs, beneficiaries, and personal representatives as if I were competent and acting on my own behalf.

COMMENCEMENT OF HEALTH CARE AGENT'S AUTHORITY

The authority granted to my health care agent under this directive shall become effective upon a determination by my attending physician that I am unable to make or communicate my own health care decisions. This authority shall remain in effect until either my death or until such time as I regain competency and formally revoke this directive.

VALIDITY OF COPIES

Any photocopy or reproduced copy of this document shall carry the same legal force and effect as the original signed document.

SEVERABILITY CLAUSE

Should any portion of any provision contained in this document be determined to be invalid or unenforceable under applicable law, such portion shall be deemed ineffective only to the extent of such invalidity, and shall not affect the validity of the remaining portions of such provision or any other provisions of this document.

EXECUTION OF DIRECTIVE

This Advance Health Care Directive has been prepared following thorough and careful consideration while I am of sound mind. I acknowledge that I am fully informed of the contents of this document and comprehend the significance of granting these powers to my designated agent. I fully understand that by affixing my signature to this document, I am authorizing my health care agent to make health care decisions on my behalf when I am no longer capable of doing so myself. I understand that this document grants my health care agent the power to provide, withhold, or withdraw consent to health care treatments or procedures on my behalf; to apply for public benefits to cover the costs of my medical treatment; and to authorize my admission to or transfer from any health care facility. I further affirm that I am not executing this document as a condition of receiving treatment or being admitted to any health care facility.

I execute this document as my free and voluntary act on:

Date of Execution: [Date of Execution]

City: [City]

County: [County]

State: [State]

Signature of Principal:

Full Legal Name: [Your full legal name]

DECLARATION OF WITNESSES

I am at least eighteen (18) years of age. I declare under penalty of perjury that the Principal signed this document or requested another person to sign on their behalf in my presence. The Principal is personally known to me or has provided sufficient evidence to establish their identity, and they signed this document voluntarily and appear to be of sound mind and free from any duress, fraud, or undue influence.

I further declare that I am not the Principal's spouse, parent, child, sibling, or otherwise related to the Principal by blood, marriage, or adoption. I declare that I have not been appointed as the Principal's health care agent, that I am not entitled to any portion of the Principal's estate to the best of my knowledge, and that I am not financially responsible for the Principal's health care expenses. I am not the Principal's health care provider, nor am I an operator or employee of any care facility or nursing home.

WITNESS 1

Signature:

Date: [Date]

Full Legal Name: [Witness 1 name]

Full Address: [Witness 1 full address]

WITNESS 2

Signature:

Date: [Date]

Full Legal Name: [Witness 2 name]

Full Address: [Witness 2 full address]

ACCEPTANCE BY HEALTH CARE AGENTS

(a) Primary Health Care Agent Acceptance

I, [Primary agent full name], hereby accept the designation as primary health care agent for [Your full l
as specified in this Advance Health Care Directive.

Signature:

Date: [Date]

Full Legal Name: [Primary agent full name]

Full Address: [Primary agent full address]

(b) Alternate Health Care Agent Acceptance

I, [Alternate agent full name], hereby accept the designation as alternate health care agent for [Your full l as specified in this Advance Health Care Directive, and agree to serve in this capacity should the primary health care agent be unable to serve.

Signature:

Date: [Date]

Full Legal Name: [Alternate agent name]

Full Address: [Alternate agent full address]

LIVING WILL DECLARATION

If I, [Your full legal name], become incapacitated and am no longer able to provide informed consent and communicate my wishes to my health care providers, I direct that this Living Will be honored as a true expression of my health care preferences.

END OF LIFE CARE INSTRUCTIONS

In the event that I develop a terminal condition that has been certified by a licensed physician as reasonably expected to result in my death within a relatively short period of time with no realistic possibility of recovery, or if I enter into an irreversible coma or permanent vegetative state that has been certified by a licensed physician as having no realistic possibility of recovery and in which it is unlikely that I will regain consciousness, I specifically direct as follows:

1. I direct that I be removed from life support systems or any other artificial means of prolonging my life, even if such removal will hasten my death.
Initials: [Initials]

2. I direct that I NOT be artificially provided with nutrition (food) or hydration (water) through tube feeding or intravenous administration, even if withholding such measures may hasten my death.
Initials: [Initials]

3. I direct that I NOT be denied comfort care and pain relief measures, including appropriate pain management medications.
Initials: [Initials]

4. I direct that cardiopulmonary resuscitation (CPR) NOT be performed on me.
Initials: [Initials]

5. I direct that NO surgical procedures be performed on me, even if my attending physicians determine such procedures would prolong my life.
Initials: [Initials]

6. I direct that chemotherapy treatments NOT be administered to me, even if my attending physicians determine such treatment would prolong my life.
Initials: [Initials]

7. I direct that radiation therapy NOT be administered to me, even if my attending physicians determine such treatment would prolong my life.
Initials: [Initials]

8. I direct that dialysis (kidney treatments) NOT be administered to me, even if my attending physicians determine such treatment would prolong my life.
Initials: [Initials]

9. I have no additional instructions regarding my end of life care.
Initials: [Initials]

ACKNOWLEDGMENT OF UNDERSTANDING

I acknowledge and understand the following:

I understand that additional options may be available to me beyond those enumerated in this document regarding my future health care, and I confirm that the instructions I have provided herein were given with full knowledge of alternatives that I have chosen to decline.

Initials: [Initials]

If my attending physician or health care facility is unwilling to follow the instructions detailed in this document, they are required to ensure that I am transferred to a physician or health care facility that will honor my wishes.

When the time arrives for the cessation of life-sustaining treatment or artificial nutrition and hydration, I direct that my attending physician discuss the benefits and risks of such action, as well as my expressed wishes, with my designated health care agent.

Name of Health Care Agent for End-of-Life Discussions: [Health care agent name]

EXECUTION OF LIVING WILL

I comprehend the full significance of this document and confirm that I am emotionally and mentally competent to execute this document. I have prepared this document following careful reflection and

consultation with my personal physician. I affirm that I am fully aware of all options available to me and that any options I have chosen to decline were intentionally omitted from the instructions above. I declare that I am a legal adult in my state of residence.

Signature of Principal:

Date: [Date]

WITNESS DECLARATION FOR LIVING WILL

I, the undersigned witness, declare under penalty of perjury that the individual who signed above is personally known to me or has proven their identity through convincing evidence. I declare that the person who signed above appeared to be at least eighteen (18) years of age and of sound mind, and executed this health care document willingly and free from fraud, duress, or undue influence. The Principal signed this document in my presence. I declare that I have not been appointed as the Principal's health care agent, that I am at least eighteen (18) years of age, that I am not entitled to any portion of the Principal's estate to the best of my knowledge, that I am not named as the Principal's health care agent, that I am not related to the Principal by blood or adoption, and that I am not financially responsible for the Principal's health care expenses. I am not the Principal's health care provider, nor am I an operator or employee of any care facility or nursing home.

WITNESS 1

Signature:

Date: [Date]

Full Legal Name: [Witness 1 name]

Full Address: [Witness 1 full address]

WITNESS 2

Signature:

Date: [Date]

Full Legal Name: [Witness 2 name]

Full Address: [Witness 2 full address]