

ADVANCE HEALTH-CARE DIRECTIVE

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 the designation of your health care provider. If you use this form, you may complete or modify all or any part of it.

Part 1 of this form is a power of attorney for health care. Part 1 lets you name another individual as agent to make health-care decisions for you if you become incapable of making your own decisions or if you want someone else to make those decisions for you now even though you are still capable. You may name an alternate agent to act for you if your first choice is not willing, able, or reasonably available to make decisions for you. Unless related to you, your agent may not be an owner, operator, or employee of a health-care institution where you are receiving care.

Unless the form you sign limits the authority of your agent, your agent may make all health-care decisions for you. This form has a place for you to limit the authority of your agent. You need not limit the authority of your agent if you wish to rely on your agent for all health-care decisions that may have to be made. If you choose not to limit the authority of your agent, your agent 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;
- (b) Select or discharge health-care providers and institutions;
- (c) Approve or disapprove diagnostic tests, surgical procedures, programs of medication, and orders not to resuscitate; and
- (d) Direct the provision, 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 medication. Space is provided for you to add to the choices you have made or for you to write out any additional wishes.

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

SAMPLE FORM
(PLEASE DO NOT SIGN)

This sample form is intended to provide you with a preview of the choices you will need to make with respect to your health care. Therefore, please review this form and think about your choices prior to the document signing meeting with our office.

ADVANCE HEALTH-CARE DIRECTIVE OF PAT D. SMITH

Preamble

I, **PAT D. SMITH**, also known as **Pat Doe Smith**, make this Advance Health-Care Directive on this _____ day of _____, 2015.

I have the right to give instructions about my own health care. I also have the right to name someone else to make health-care decisions for me. In the Advance Health-Care Directive which follows this Preamble, I have done either or both of these things. The Advance Health-Care Directive also allows me to express my wishes regarding the designation of my health care provider. I understand that I may complete or modify all or any part of my Advance Health-Care Directive. I also understand that I am free to use a different form. **I understand that I have the right to revoke this Advance Health-Care Directive or replace this form at any time.**

Options are presented to me in the Advance Health-Care Directive which follows this Preamble. My choices will be shown by my initialing the lines and checking the boxes adjacent to the provisions I select. I will cross out or strike through the options that I do not select. I will also cross out or strike through any provisions that I wish to delete.

My Advance Health-Care Directive consists of the following parts:

_____ **PART 1: Durable Power of Attorney for Health Care Decisions:** Part 1 lets me name another individual as agent to make health care decisions for me if I become incapable of making my own decisions or if I want someone else to make those decisions for me now even though I am still capable. I may name an alternate agent to act for me if my first choice is not willing, able or reasonably available to make decisions for me. Unless related to me, my agent may not be an owner, operator or employee of a health-care institution where I am receiving care. Unless the form I sign limits the authority of my agent, my agent may make all health-care decisions for me. The form has a place for me to limit the authority of my agent, but I need not limit the authority of my agent if I wish to rely on my agent for all health-care decisions.

_____ **PART 2: Instructions for Health Care:** Part 2 of this form lets me give specific instructions about any aspect of my health care. Choices are provided for me to express my wishes regarding the provisions, withholding, or withdrawal of treatment to keep me alive, including provision of artificial nutrition and hydration, as well as provision of pain relief medication. Space is provided for me to add to the choices I have made or for me to write out any additional wishes.

Initials: _____

_____ **PART 3: Donation of Organs/Body at Death:** Part 3 of this form lets me choose whether I wish to donate my organs and/or body at my death.

_____ **PART 4: Primary Physician:** Part 4 of this form lets me designate a physician to have primary responsibility for my health care.

SAMPLE

Initials: _____

PART 1
DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

(1) DESIGNATION OF AGENT: I designate the following individual as my agent to make health-care decisions for me:

BETTY SMITH

Address: _____
Home phone: _____
Work phone: _____

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

FRANK SMITH

Address: _____
Home phone: _____
Work phone: _____

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

JANE SMITH

Address: _____
Home phone: _____
Work phone: _____

If my spouse has been appointed as my agent or as an alternate agent hereunder and subsequent to the execution of this Advance Health-Care Directive an action shall be filed to dissolve our marriage or to initiate legal separation, then the filing of such action shall automatically terminate my spouse's authority as my agent or alternate agent.

(2) AGENT'S AUTHORITY: My agent is authorized to make all of the following health-care decisions for me:

- * To consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition, including approval or disapproval of diagnostic tests, medical or surgical procedures, programs of medication, the use of alternative or complementary therapies as well as decisions to participate in education, research and experimental programs.
- * To make decisions regarding orders not to resuscitate as well as decisions to provide, withhold, or withdraw artificial nutrition and hydration, and all other forms of health care to keep me alive.

Initials: _____

- * To elect and discharge health-care providers, companions, organizations, institutions and programs and to make and change health-care choices and options relating to plans, services, and benefits.
- * To apply for public or private health-care programs, to include Medicare, Medicaid, and Hawaii Quest benefits without my agent incurring any personal financial liability.
- * To grant releases to hospital staff, physicians, nurses, and other medical and hospital administrative personnel who act in reliance on instructions given by my agent or who render written opinions to my agent in connection with any matter described in this form from all liability for damages suffered or to be suffered by me; to sign documents titled or purporting to be a "Refusal to Accept Treatment" or "Leaving Hospital Against Medical Advice," as well as any necessary waivers of or releases from liability required by a hospital or physician to implement my wishes regarding medical treatment or lack of treatment.
- * To request, receive, examine, copy, and consent to the disclosure of medical or any other health-care information, whether verbal or written.
- * To make all other health-care decisions for me, except as I state here:

Initials: _____

(3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE:

_____ My agent's authority becomes effective when my primary physician determines that I am unable to make my own health-care decisions.

_____ My agent's authority to make health-care decisions for me takes effect immediately.

(4) AGENT'S OBLIGATION: My agent 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 agent. To the extent my wishes are unknown, my agent shall make health-care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

(5) NOMINATION OF GUARDIAN: If a guardian of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able, or reasonably available to act as guardian, I nominate the alternate agents whom I have named, in the order designated.

(6) HIPAA RELEASE AUTHORITY: I intend for my agent to 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 (also known as HIPAA), 42 USC 1320d and 45 CFR 160-164 and any amendment to HIPAA. I authorize: any physician, healthcare 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, to include all information relating to the diagnosis and treatment of HIV/AIDS, sexually transmitted diseases, mental illness and drug or alcohol abuse.

Initials: _____

The authority given my agent supersedes any prior 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.

(7) ACCESS ELECTRONIC HEALTH INFORMATION: I authorize my agent to access my electronic personal health information and records and to utilize my health care provider's online patient portal.

SAMPLE

Initials: _____

PART 2
INSTRUCTIONS FOR HEALTH CARE

(8) 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:

_____ **(a) Choice Not to Prolong Life:** I do not want my life to be prolonged if:

- (i) I have an incurable and irreversible condition that will result in my death within a relatively short time;
- (ii) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness; or
- (iii) the likely risks and burdens of treatment would outweigh the expected benefits; OR

_____ **(b) Choice To Prolong Life:** I want my life to be prolonged as long as possible within the limits of generally accepted health-care standards.

(9) ARTIFICIAL NUTRITION AND HYDRATION:

_____ If I mark this box, artificial nutrition and hydration must be withheld or withdrawn in accordance with the choice I have made in paragraph (8).

_____ If I mark this box, artificial nutrition and hydration must be provided regardless of my condition and regardless of the choice I have made in paragraph (8).

(If neither provision is chosen, or if both are chosen, it shall be presumed that I want artificial nutrition and hydration to be provided.)

Initials: _____

(10) RELIEF FROM PAIN:

_____ If I mark this box, I direct that treatment to alleviate pain or discomfort should be provided to me even if it hastens my death.

_____ If I mark this box, I direct that treatment to alleviate pain or discomfort should not be provided to me if it hastens my death.

(If neither provision is chosen, or if both are chosen, it shall be presumed that I want treatment to alleviate pain or discomfort.)

(11) OTHER WISHES:

I direct that: _____

SAMPLE

Initials: _____

PART 3
DONATION OF ORGANS/BODY AT DEATH

(12) Upon my death:

_____ (a) I give any needed organs, tissues, or parts OR

_____ (b) I give the following organs, tissues, or parts only:

_____ (c) My gift is for the following purposes which I have checked and initialed:

_____ Transplant

_____ Therapy

_____ Research

_____ Education

_____ Other: _____

_____ (d) I give my body to the John A. Burns School of Medicine for its research and education purposes.

Initials: _____

**PART 4
PRIMARY PHYSICIAN**

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

(Name of physician)

(Address) (City) (State) (Zip code)

(Phone)

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 primary physician:

(Name of physician)

(Address) (City) (State) (Zip code)

(Phone)

Initials: _____

(14) APPLICABLE LAW: My Advance Health-Care Directive shall be governed by the laws of the State of Hawaii in all respects, including its validity, construction, interpretation, and termination. I intend for this Advance Health-Care Directive to be honored in any jurisdiction where it may be presented and for any such jurisdiction to refer to State of Hawaii law to interpret and determine the validity of this Advance Health-Care Directive and any of the powers granted under this Advance Health-Care Directive.

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

(16) SIGNATURES:

PAT D. SMITH
1234 Main Street
Honolulu, Hawaii 96822

(Date)

(17) WITNESSES: This power of attorney will not be valid for making health-care decisions for me unless it is either (a) signed by two qualified adult witnesses who are personally known to me and who are present when I sign or acknowledge my signature; or (b) acknowledged before a notary public in Hawaii.

ALTERNATIVE NO. 1

First Witness

I declare under penalty of false swearing pursuant to section 710-1062, Hawaii Revised Statutes, that PAT D. SMITH, the principal, is personally known to me, that the principal signed or acknowledged this 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 agent by this document, and that I am not a health-care provider, nor an employee of a health-care provider or facility. 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.

Printed: _____

(Date)

Address: _____

Second Witness

I declare under penalty of false swearing pursuant to section 710-1062, Hawaii Revised Statutes, that the principal is personally known to me, that the principal signed or acknowledged this power of attorney in my presence, that PAT D. SMITH, the principal, appears to be of sound mind and under no duress, fraud, or undue influence, that I am not the person appointed as agent by this document, and that I am not a health-care provider, nor an employee of a health-care provider or facility. 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.

Printed: _____

(Date)

Address: _____

ALTERNATIVE NO. 2

STATE OF HAWAII)
) SS:
CITY AND COUNTY OF HONOLULU)

On this _____ day of _____, 2015, in the First Circuit of the State of Hawaii, before me personally appeared **PAT D. SMITH**, to me known to be the person described in and who executed this _____-page ADVANCE HEALTH-CARE DIRECTIVE OF **PAT D. SMITH**, dated _____, and acknowledged that he or she executed it.

(seal)

Notary Public, State of Hawaii

Notary's Printed Name

My commission expires:_____