Use of This Form Subject To Our Terms of Use: As Outlined On Our Website: It is understood that this form has been provided as a free courtesy and as a condition of its use, anyone who utilizes it agrees to take full responsibility for use and completion of this form and acknowledges understanding that its use creates no expectation of any attorney-client relationship.

The Advance Health Care Directive

The Advance Health Care Directive is the new terminology for a document that combines the functions of the both the Living Will and Power of Attorney for Health Care. The Advance Health Care Directive is now the most up to date, comprehensive document for stating your health care wishes and empowering someone to interface with medical personnel and make decisions if you are unable.

Instructions:

Part 1:
First print your name where indicated; then print the name your chosen agent where indicated. You will also find spaces for optionally naming up to two other alternate agents if you would like.

Part 2:
Here **you have the option to affirm that your agent's authority is to start now.** We suggest that you strongly consider signing this. By signing on the line in part 2 you presently empower your agent to be your concurrent advocate and helper. Otherwise, if you do not sign part 2 you will have to be fully incapacitated before your agent is allowed to participate and because of strict privacy laws, you risk denying even your spouse or closest loved one the ability to provide input or receive any information in a medical situation or emergency. It doesn't matter if it is your parent, partner, best friend, sibling or adult child, if this line is not signed they may be unable to get answers, discuss your condition and treatment, or even help in the ways you may need or want.

Part 3:
This section allows you to express some overall wishes regarding end of life care and life support. Though completing this section is entirely optional, many seem to want to express a preference that no extra-ordinary measures be used that would needlessly prolong dying and suffering. If you would like to do so then you will want to consider reading and signing option A. Remember however that you have already empowered your agent to make these kinds of calls and by leaving this section blank you are essentially saying you would rather leave it up to your agent's best judgment – an approach that many prefer.

Part 4
Once you have completed part 1, 2, & 3 you should sign and date your directive where indicated.

Final Step:
Now all you have to do is have the directive **witnessed or notarized for it to** become legally enforceable – and you should do so right away. For many reasons we believe notarizing is best especially since many directives are improperly witnessed. If you have it notarized be sure that the notary properly signs, stamps, and completes the notary area in Part 5. If you have it witnessed be sure to very carefully follow the instructions and procedures detailed in Part 6.

Advance Health Care Directive

(Power of Attorney for Health Care)

1. Designation & Appointment of Health Care Agent

I,_____

(Print Name of Principal above)

hereby designate and appoint the below named person, as my agent to make health care decisions authorized in this document:

_____

Print Name of Primary Health Care Agent above

Designation of Alternate Agents (optional):

If the person I designated as my primary agent above is not reasonably available, unable or unwilling to act as my agent, or I revoke (oral or written) that person's appointment as my agent, then I designate the following persons to serve as my agent, in the order listed below, to act as my health care agent and to make health care decisions for me, as authorized in this document:

First Alternate Agent: _____

(Please Print Name Above)

Second Alternate Agent:_____

(Please Print Name Above)

2. Authority of Agent & When It Is To Become Effective

I understand that I can specify when my agent's authority to make health care decisions for me begins, either: (1) only when I become unable to make health care decisions for myself, or (2) immediately, even though I am still able to make health care decisions for myself.

By my signature below I hereby confirm that my agent's authority under this directive is effective immediately upon my signing this directive. If I do not sign the line below then I only want my agent's authority to begin when I become unable to make health care decisions for myself.

X _____

My Signature Above Confirms I Want My Agents Authority To Be Effective <u>Immediately</u> and This Paragraph Is Statement of My Overall Intent: In signing the above line, my purpose and intent in making my agent's authority immediately effective is to empower my agent to be my concurrent partner, helper, advocate, and liaison in my medical care, unhindered by any medical privacy barriers that would otherwise impede them in these efforts or prevent medical personnel from openly discussing my condition or disclosing or distributing my personal medical information to my agent. In other words, I give my full permission for the hospitals, doctors and other medical personnel to currently interact, and communicate with my appointed agent to the same extent that I could – including the power to obtain and consent to the release of any and all medical information, past or present.

(Authority of Agent Continued on the Next Page)

Authority of Agent (continued)

- ***My Agent Is Currently Authorized to Exercise These Powers if The Line On the Previous Page Is Signed:*** *Even though I am still able to make medical decisions for myself, if I have signed the line on the previous page my agent is currently vested with the powers and authority detailed on this page. Otherwise, if I have NOT signed the line on the previous page, my agent is only authorized to act and use these powers when I become unable to make health care decisions for myself.*

- **My Agent is Empowered to Consent, Refuse Consent, or Withdraw Consent on My Behalf:** I grant to my agent full power and authority to consent, refuse consent, or withdraw consent to any type of health care procedure (including any procedure to maintain, diagnose, or treat any physical or mental condition), to choose or reject my physician, other health care professionals or health care facilities, or to make any other health care decision, to the same extent that I could subject to the terms of this instrument. Whenever reasonably possible however, my agent and medical personnel shall first make a good faith effort to communicate with me and consult with me regarding my own desires in these regards unless such attempts would be futile, impractical, or if the resulting delay would likely be a serious threat to my health or life. Under no circumstances shall my agent be allowed to override me when I have the requisite capacity to make my own medical decisions.

- **My Agent is Empowered to Interface & Communicate With All Medical Personnel on My Behalf:** Consistent with the aforementioned, I hereby empower my agent to consult with and advise any physicians, nurses, therapists, dentists, or any other medical or health care institutions on my behalf, as such consultations relate to my health, welfare, and condition. All such personnel and institutions are specifically requested to abide by all decisions and instructions of my agent and to release to my agent all information that my agent may request concerning my health and wellbeing.

- **Consent to Disclose Confidential Medical Information to My Agent (HIPAA & Other Medical Privacy Act Waivers)**: Accordingly my agent's ability to act shall NOT be restricted, impeded, or hindered by any medical privacy laws including but not limited to HIPAA, & California Confidentiality of Medical Information Act or any other state or federal medical privacy laws. I hereby consent to the disclosure of all confidential medical information to my agent -- and hereby waive any such restrictions on my agent's ability to act. Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (42USC 1320d and 45 CFR parts 106, 164) and the California Confidentiality of Medical Information Act (Civil Code 56-56.37), (and any other Federal or State Medical Privacy Laws) I authorize all health care providers and covered entities to disclose to my agent under my advance health care directive, at my agent's request, all of my individually identifiable health and medical information and medical records regarding any past, present, or future medical or mental health condition.

- **My agent is also empowered to authorize an autopsy** and dispose of my body, unless I have said something different in a contract with a funeral home, in my will, or by some other written method.

- **Limitations:** My agent **may not** consent to committing me to or placing me in a mental health treatment facility, or to convulsive treatment, psychosurgery, sterilization or abortion.

3. Instructions for Health Care (optional)

Please Note: ***This section is entirely optional*** *and designed only for those of you who wish to set forth specific instructions regarding your health care. Remember, you have already empowered your agent to make the kind of health care decisions contemplated herein and many believe no amount of written instructions can ever substitute for the better judgment of someone you trust. If you leave this section blank you are essentially saying you would rather leave these decisions up to your agent's best judgment taking in all the facts and circumstances as they exist at the time. For those of you who would instead like to set forth some specific instructions regarding end of life care and life support you can optionally utilize any of the following:*

Option A: Please Do NOT Prolong My Dying & Suffering	**Option B: Please Prolong My Life To The Greatest Extent Possible**
By signing below I am expressing my desire that if my death is imminently expected or expected within a matter of months because I am suffering from an incurable or irreversible terminal condition and if the application of life-sustaining procedures would serve only to postpone the moment of my death, then excepting those treatments needed to keep me comfortable, I request that all other treatments and procedures be withheld or withdrawn, and that I be permitted to die naturally. _____ **Only sign the above line if you choose this option**	By signing below I express the desire that my life be prolonged to the greatest possible extent without regard for my physical or mental condition, chance of recovery, likelihood of suffering, or expense, and I authorize my agent to consent to whatever medical procedures are necessary to accomplish this end. _____ **Only sign the above line if you choose this option**

Optional: Other Instructions

I have attached other health care instructions to this directive consisting of _____pages.
I have signed and dated each of these attached pages the same date as this directive.

4. Signing Your Advance Health Care Directive

By my signature below:

1. I hereby affirm this Advance Health Care Directive

2. I also affirm that this form has been provided as a free courtesy and I take full responsibility for use and completion of this form and I understand that its use creates no expectation of any attorney-client relationship.

3. I also affirm that **any copy of this Advance Health Care Directive shall have the same full legal force and effect as the original**.

Date: _____

(Place Signature on the above line)

Please Print Name: _____

*Important Note: This Advance Health Directive **must be notarized or witnessed for it to become effective and legally enforceable** – and you should do so right away. For many reasons we believe notarizing is best especially since many directives are improperly witnessed. If you have it witnessed be sure to carefully follow the instructions and procedures detailed on the Witness page.*

5. Notarizing Your Advance Health Care Directive

Note: Be sure that the notary properly signs, stamps, and fully completes the notary area.

Acknowledgement

A Notary Public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached and not the truthfulness, accuracy, or validity of that document.

State of California

County of _____

On _____ before me, _____ **(notary public),**

personally appeared _____who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument. I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

Witness my hand and official seal.

_____

Signature of Notary

6. Witnessing Your Advance Health Care Directive

(this does not need to be completed if this document has been notarized)

***Warning*: If you choose to have this directive witnessed it requires two independent, disinterested witnesses and you should be very careful that both witnesses meet the qualifications and criteria listed below and can affirm the following under penalty of perjury:**

Witness Qualifications and Statements

I declare under penalty of perjury under the laws of California or any other state that (1) the person who signed or acknowledged this advance health care directive is personally known to me, or that the identity of the individual was proved to me by convincing evidence, (2) the individual signed or acknowledged this advance directive in my presence, (3) the individual appears to be of sound mind and under no duress, fraud, or undue influence, (4) I am at least 18 years old and I am not the person appointed as agent by this advance health care directive, and (5) I am not the individual's health care provider, an employee of the individual's health care provider, the operator of a community care facility, the operator of a residential care facility for the elderly, or an employee of the operator of a residential care facility for the elderly.

First Witness	Second Witness
Date:_____	Date:_____
Signature:_____	Signature:_____
Print Name:_____	Print Name:_____
Resident Address:_____	Resident Address:_____
_____	_____

ONE OF THE ABOVE WITNESSES MUST ALSO SIGN THE FOLLOWING DECLARATION:

I further declare under penalty of perjury under the laws of California that I am not related to the individual executing this advance health care directive by blood, marriage or adoption, and, to the best of my knowledge, I am not directly or indirectly entitled to any part of the individual's estate upon his or her death under a will now existing or by operation of law or any other means.

Date:_____ Signature:_____

FOR SKILLED NURSING FACILITIES :*If you are a patient in a skilled nursing facility, you must have a patient advocate or ombudsman sign both the Statement of Witnesses (above) and the following declaration*: I further declare under penalty of perjury under the laws of California that I am a patient advocate or ombudsman as designated by the State Department of Aging and am serving as a witness as required by Probate Code 4675

Print Name/Title_____

Address:_____

Date:_____ Signature:_____