

ADVANCE HEALTH CARE DIRECTIVE
(California Probate Code Section 4701)
for



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 donation of organs and the designation of your primary physician. If you use this form, you may complete or modify all or any part of it. You are free to use a different form.

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 also name an alternate agent to act for you if your first choice is not willing, able, or reasonably available to make decisions for you. (Your agent may not be an operator or employee of a community care facility or a residential care facility where you are receiving care, or your supervising health care provider or employee of the health care institution where you are receiving care, unless your agent is related to you or is a coworker.)

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:

1. Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition.
2. Select or discharge health care providers and institutions.
3. Approve or disapprove diagnostic tests, surgical procedures, and programs of medication.
4. Direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care, including cardiopulmonary resuscitation.
5. Make anatomical gifts, authorize an autopsy, and direct disposition of remains.

PART 2 of this form lets you give specific instructions about any aspect of your health care, whether or not you appoint an agent. Choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive, as well as the provision of pain relief. Space is also provided for you to add to the choices you have made or for you to write out any additional wishes. If you are satisfied to allow your agent to determine what is best for you in making end-of-life decisions, you need not fill out Part 2 of this form.

PART 3 of this form lets you express an intention to donate your bodily organs and tissues following your death.

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

After completing this form, sign and date the form at the end. The form must be signed by two qualified witnesses or acknowledged before a notary public. Give a copy of the signed and completed form to your physician, to any other health care providers you may have, to any health care institution at which you are receiving care, and to any health care agents you have named. You should talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take the responsibility.

You have the right to revoke this advance health care directive or replace this form at any time.

PART 1
POWER OF ATTORNEY FOR HEALTH CARE

1.1 DESIGNATION OF AGENT

I, , designate the following individual as my agent to make health care decisions for me:

(name of agent)

(street address)

(city/state/zip)

Home: _____
Business: _____
Cell: _____
Email: _____

[OPTIONAL]

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:

(name of first alternate agent)

(street address)

(city/state/zip)

Home: _____
Business: _____
Cell: _____
Email: _____

[OPTIONAL]

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:

(name of second alternate agent)

(street address)

(city/state/zip)

Home: _____
Business: _____
Cell: _____
Email: _____

1.2 AGENT'S AUTHORITY

My agent is authorized to make all health care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care to keep me alive, except as I state here:

[Add additional sheets if needed]

1.3 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 unless I initial the following item. If I initial this space _____, my agent's authority to make health care decisions for me takes effect immediately.

1.4 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.

1.5 AGENT'S POSTDEATH AUTHORITY

My agent is authorized to make anatomical gifts, authorize an autopsy, and direct disposition of my remains, except as I state here or in Part 3 of this form:

[Add additional sheets if needed]

1.6 NOMINATION OF CONSERVATOR

If a conservator 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 conservator, I nominate the alternate agents whom I have named, in the order designated.

1.7 HIPAA AUTHORIZATION

I grant to my agent and successor agent(s) under this advance health care directive the authority to advocate for my health care needs even if I have not been determined to lack capacity.

This release shall apply to any of my information which is governed under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 USC §1320d and 45 CFR pts 160, 164, and California law. I intend my agent and successor agent(s) to be dealt with by all my health care providers, as required by HIPAA and California law, in the exact same way as I

would be treated with respect to my rights regarding the use and disclosure of my identifiable protected health information or other medical records.

Pursuant to HIPAA and California law, I authorize any covered entity, including, but not limited to, any physician, health care professional, dentist, health plan, hospital, nursing home, clinic, laboratory, pharmacy, or any 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 to be paid for services, to give, disclose, and release to my agent and successor agent(s), without restriction and at the request of my agent and successor agent(s), all of my individually identifiable health information and medical records regarding any past, present, or future medical or mental health condition, including, but not limited to, any and all information relating to the diagnosis and treatment of sexually transmitted diseases, mental illness (including information contained in mental health records protected by the Lanterman-Petris-Short Act), HIV/AIDS, and drug or alcohol abuse.

I understand that:

I may revoke this authorization at any time by written notice to the covered entity;

This authorization shall expire on the date of my death unless validly revoked prior to that date.

The covered entity may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign an authorization unless the law allows conditions;

I have a right to a copy of this authorization; and

Under California law, all recipients of protected health care information may not redisclose it except as required or permitted by law.

Information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by HIPAA regulations.

This authority shall supersede 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 to my agent and successor agent(s) shall expire in the event that I revoke this authority in writing and deliver it to my health care provider.

PART 2
INSTRUCTIONS FOR HEALTH CARE

[IF YOU FILL OUT THIS PART OF THE FORM, YOU MAY STRIKE ANY WORDING YOU DO NOT WANT]

2.1 **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 initialed below:

_____ **CHOICE NOT TO PROLONG LIFE** - I do not want my life to be prolonged if (1) I have an incurable and irreversible condition that will result in my death within a relatively short time, (2) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (3) the likely risks and burdens of treatment would outweigh the expected benefits, OR

_____ **CHOICE TO PROLONG LIFE** - I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

2.2 **RELIEF FROM PAIN**

Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death:

[Add additional sheets if needed]

2.3 **OTHER WISHES**

(If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:

[Add additional sheets if needed]

PART 3
DONATION OF ORGANS AT DEATH

[OPTIONAL]

3.1 Upon my death, I give any needed organs, tissues, or parts, (mark box to indicate yes). By checking the box above, and notwithstanding my choice in Part 2 of this form, I authorize my agent to consent to any temporary medical procedure necessary solely to evaluate and /or maintain my organs, tissues, and/or parts for purposes of donation.

My gift is for the following purposes (initial any of the following you want):

- Transplant
- Therapy
- Research
- Education

If you want to restrict your donation of an organ, tissue, or part in some way, please state your restriction on the following lines.

If I leave this part blank, it is not a refusal to make a donation. My state-authorized donor registration should be followed, or, if none, my agent may make a donation upon my death. If no agent is named above, I acknowledge that California law permits an authorized individual to make such a decision on my behalf (to state any limitation, preference or instruction regarding donation, please use the lines above or in Section 1.5 of this form).

PART 4
PRIMARY PHYSICIAN

[OPTIONAL]

4.1 I designate the following physician as my primary physician:

(name of primary physician)

(location of primary physician)

[OPTIONAL]

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 alternate primary physician:

(name of alternate primary physician)

(location of alternate primary physician)

PART 5
ADMINISTRATIVE PROVISIONS

5.1 **REVOCATION**

By signing this document, I hereby revoke all prior health care directives and powers of attorney.

5.2 **EFFECT OF COPY**

A copy of this form has the same effect as the original.

5.3 **SIGNATURE**

Dated: _____, 20__

Printed Name:

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)
) ss.
County of)

On _____ 20__, before me, _____, Notary Public, personally appeared _____, who proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her authorized capacity, and that by his/her signature on the instrument the person, or the entity upon behalf of which the person 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.

Notary Public
Commission Number:
My commission expires:
_____ County, California
Manufacturer:
Telephone:

STATEMENT OF WITNESSES

YOU SHOULD CAREFULLY READ AND FOLLOW THIS WITNESSING PROCEDURE. THIS DOCUMENT WILL NOT BE VALID UNLESS YOU COMPLY WITH THE WITNESSING PROCEDURE. IF YOU ELECT TO USE WITNESSES INSTEAD OF HAVING THIS DOCUMENT NOTARIZED YOU MUST USE TWO (2) QUALIFIED ADULT WITNESSES. NO WITNESS MAY BE A PERSON THAT YOU DESIGNATE AS ONE OF YOUR ATTORNEYS-IN-FACT.

I declare under penalty of perjury that the principal is personally known to me, that the principal signed or acknowledged this Durable 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 attorney-in-fact by this document.

[Signature of Witness]

[street address]

[city, state and zip code]

[Signature of Witness]

[street address]

[city, state and zip code]

SPECIAL WITNESS REQUIREMENT

The following statement is required only if you are a patient in a skilled nursing facility -- a health care facility that provides the following basic services: skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis. The patient advocate or ombudsman must sign the following statement:

STATEMENT OF PATIENT ADVOCATE OR OMBUDSMAN

I 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 that I am serving as a witness as required by Section 4675 of the Probate Code.

(date) (sign your name)

(address) (print your name)