ADVANCE HEALTH CARE DIRECTIVE

I, _____, born _____, of _____, in _____ County, State of _____, am an adult of sound mind. I make this advance directive of my own free will. Part 1 names a health care agent and Part 2 gives my treatment instructions. I may complete either part or both; I have crossed out and initialed any part I do not use. I revoke every earlier advance directive, living will and health care power of attorney.

Before you use this form: states differ on who may witness it, whether a notary is needed, who may serve as an agent, and whether their own form is expected. Check your state's rules, or use the LawVault builder, which applies them for you.

1. PART 1: HEALTH CARE AGENT

I appoint _____, of _____, phone _____, as my health care agent. If my agent is not willing, able or reasonably available to act, I appoint _____, phone _____, as my alternate agent.

My agent may make any health care decision for me that I could make myself, including consenting to, refusing or stopping any treatment, including life-sustaining treatment, choosing providers and facilities, and seeing and releasing my medical records. This appointment is not affected by my later disability or incapacity.

My agent's authority begins (initial one): ____ when my doctor finds in writing that I cannot make or communicate my own decisions ____ right away, though my own decisions control while I can make them.

My agent must follow my instructions in Part 2 and my other known wishes, and decide in my best interest where my wishes are unknown. My agent may not: _____.

After my death, my agent may (initial any): ____ authorize or refuse an autopsy ____ decide how my remains are handled ____ make gifts of my organs and tissues, if I have not decided in Part 3. If a court must appoint a guardian of my person, I nominate my agent.

2. PART 2: TREATMENT INSTRUCTIONS

These instructions apply only when I cannot make or communicate my own decisions and my attending physician and one other physician agree, in my medical record, that I have a terminal condition, am permanently unconscious, or have an end-stage condition, with no reasonable chance of recovery.

Life-sustaining treatment (initial one): ____ Do not prolong my life; keep me comfortable. ____ Try treatment for up to _____ days, then stop if I am not getting better. ____ Prolong my life as long as medically reasonable.

INITIAL ONE. TUBE FEEDING AND IV FLUIDS: ____ I DO NOT WANT THEM, AND IF STARTED, I WANT THEM STOPPED. ____ I WANT A TRIAL FOR UP TO _____ DAYS, THEN STOPPED IF I AM NOT GETTING BETTER. ____ I WANT THEM GIVEN TO ME. I UNDERSTAND THAT STOPPING THEM MAY LEAD TO MY DEATH.

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Comfort care continues at all times. Pain relief (initial one): ____ control my pain fully, even if it makes me drowsy or may shorten my life ____ control my pain but keep me as alert as possible.

If I am pregnant (initial one, if it applies): ____ follow my instructions as written, as far as the law allows ____ continue treatment if the fetus could develop to live birth ____ continue treatment for the rest of the pregnancy.

Other wishes (hospice, where I would like to be, spiritual requests): _____

3. PART 3: ORGAN AND TISSUE DONATION

Initial one: ____ At my death, I give any organs or tissues that can be used. ____ I give only these parts: _____. ____ I do not want to donate. ____ I make no decision here. Allowed purposes (initial any): ____ transplant ____ therapy ____ research ____ education.

4. PART 4: RECORDS AND GENERAL TERMS

My primary physician: _____, phone _____.

I authorize my health care providers and health plans to disclose my health information, including my complete medical records, to my agent, my alternate agent and _____, so they can help make and carry out decisions about my care. This authorization takes effect now and ends two years after my death. I may revoke it in writing at any time, except where a provider has already acted on it. My treatment will not be conditioned on signing it, and information shared under it may be shared again and lose federal privacy protection.

I may revoke this document at any time by destroying it, signing a dated revocation, telling my doctor, or signing a new directive. A copy has the same effect as the original. This document is not a POLST or do-not-resuscitate order; emergency crews may need one of those, signed by my clinician. If part of this document is invalid, the rest still applies.

SIGNATURES

Principal

Signature: _____ Date: _____

Printed Name: _____

WITNESSES

Each witness states: I am an adult. I saw the principal sign, or the principal told me the signature is theirs. The principal appears to be of sound mind and free of pressure. I am not the principal's agent or alternate agent, not related to the principal by blood, marriage or adoption, not entitled to any part of the principal's estate, not financially responsible for the principal's care, and not the principal's doctor or an employee of a provider or facility caring for the principal.

Witness 1: _____ Printed name: _____ Date: _____

Witness 2: _____ Printed name: _____ Date: _____

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NOTARY ACKNOWLEDGMENT (IF YOUR STATE USES ONE)

State of _____, County of _____. On _____, before me, the undersigned notary public, personally appeared _____, proved to me through satisfactory evidence of identity to be the person who signed this document, and acknowledged signing it voluntarily.

Notary Public: _____ My commission expires: _____ (Seal)

AGENT'S ACCEPTANCE (OPTIONAL IN MOST STATES)

I accept this appointment and will act in good faith, following the principal's written instructions and known wishes.

Agent: _____ Date: _____ Alternate agent: _____ Date: _____

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