# ADVANCE HEALTH CARE DIRECTIVE

Including Power of Attorney for Health Care
and Individual Health Care Instruction

## INSTRUCTION SHEET

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. You may complete or modify all or any part of this form.

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

### Designation of Health Care Agent

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. You may also name alternate agents 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.)

### Authority of Agent

Unless you limit the authority of your agent on this form, 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. Nothing in this form authorizes your agent under this Power of Attorney for Health Care to make a health care decision if you object to the decision. If you object to the health care decision of the agent under this Power of Attorney for Health Care, the matter will be governed by the law that would apply if there were no power of attorney for health care.

### Agent's Postdeath Authority

This part of the form lets you express an intention to donate your bodily organs and tissues following your death.

## PART 2: INDIVIDUAL HEALTH CARE INSTRUCTION

Part 2 of this form lets you give specific instructions about any aspect of your health care, whether or not you appoint an agent. 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. 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 artificial nutrition (food), hydration (water), and 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 necessary, you may attach additional sheets for this purpose.

## PART 3: MISCELLANEOUS PROVISIONS AND EXECUTION

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. Each witness signing the advance directive shall witness either the signing of the advance directive by the patient or the patient's acknowledgment of the signature or the advance directive. A "qualified witness" is an adult and cannot be any of the following:

- Your health care provider or an employee of your health care provider;
- The operator or an employee of a community care facility;
- The operator or an employee of a residential care facility for the elderly; or
- The person you named as your agent in Part 1 of this form.

### Special Witness Requirement

In addition to the limitations above, at least one of the witnesses shall be an individual who is neither related to you by blood, marriage, or adoption, nor entitled to any portion of your estate upon your death under a will or trust existing when this form is signed.

### Statement of Patient Advocate or Ombudsman

If you are a patient in a skilled nursing facility when this form is signed, this advance health care directive is not effective unless a patient advocate or ombudsman signs the advance directive as a witness. This is a requirement even if this form is notarized.

### Certificate of Acknowledgement of Notary Public

Notarization is only necessary if qualified witnesses are not available or if you prefer notarization instead of witnesses.

**If you have any questions about how to complete this form, please call Meta *law, inc.* at (805)856-3400.**

# ADVANCE HEALTH CARE DIRECTIVE

Including Power of Attorney for Health Care
and Individual Health Care Instruction

***Before completing this form, please review the instructions provided separately. If you have any questions about the meaning or effect of this document, call META law, inc. at (805)856-3400.***

## PART 1: POWER OF ATTORNEY FOR HEALTH CARE

### Designation of Health Care Agent

I, _____, born on _____:

(*CHOOSE ONE*)

☐ do not wish to appoint an agent at this time.

☐ hereby designate the following person as my agent to make health care decisions for me:

Name: _____

Address: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Fax Number: _____

If I revoke my agent's authority, if my agent is not readily able to be contacted without undue effort, or if my agent is not willing or not able to act in a timely manner considering the urgency of my health care needs, then I designate the following person to do so:

1st Alternate Agent (*OPTIONAL*):

Name: _____

Address: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Fax Number: _____

If I revoke my 1st alternate agent's authority, if my 1st alternate agent is not readily able to be contacted without undue effort, or if my 1st alternate agent is not willing or not able to act in a timely manner considering the urgency of my health care needs, then I designate the following person to do so:

2nd Alternate Agent (*OPTIONAL*):

Name: _____

Address: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Fax Number: _____

### Authority of Agent

Except as limited by this document, my agent is authorized to make all health care decisions for me to the extent that I now have authority to make my own health care decisions. This authority includes, but is not limited to, the authority to:

A. Consent, refuse consent, or withdraw consent to any medical care or services, such as tests, drugs, surgery, or consultations for any physical or mental condition. This includes the provision, withholding or withdrawal of artificial nutrition and hydration (feeding by tube or vein) and all other forms of health care, including cardiopulmonary resuscitation (CPR).

B. Choose or reject my primary physician, other health care providers or health care institutions.

C. Receive and consent to the release of medical information and records.

I understand that, by law, my agent may not consent to committing me or placing me in a mental health treatment facility, or to convulsive treatment, psychosurgery, sterilization or abortion.

## Agent's Authority Under HIPAA and CMIA

My agent shall be my personal representative under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 USC §1320d and 45 CFR parts 160, 164, and the California Confidentiality of Medical Information Act (CMIA), Civil Code §§ 56 – 56.37 and shall have the same rights as I have to request, receive, examine, copy and authorize the disclosure of my protected health information.

## When Agent's Authority Becomes Effective

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

## Obligations of Agent

My agent must 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 wishes to the extent known by my agent. To the extent my wishes are unknown, my agent shall make health care decisions that my agent believes to be in my best interest, considering my personal values to the extent they are known to my agent.

My agent shall provide a copy of this advance health care directive to any health care provider or facility that takes on responsibility for my care.

## Agent's Post Death Authority

My agent has the authority to authorize an autopsy and direct disposition of my remains unless I have said something different in a contract with a funeral home, in my will or trust, or by some other written method.

(*MARK ONLY ONE OF THE FOLLOWING)*

☐ I do not wish to be an organ donor and my agent does ***not*** have the authority to make anatomical gifts.

☐ I wish to be an organ donor and my agent does have the authority to carry out the following anatomical gift:

**Upon my death, I give:** (*MARK ALL THAT APPLY*)

- ☐ my body
- ☐ any needed organ (e.g., kidneys, liver, heart, lungs, pancreas, spleen), tissue (corneas, heart valves, skin, bone) or parts
- ☐ only the following organs, tissues, or parts:_____

_____

_____

**to:** (*MARK ONE*)

- ☐ the regional organ procurement agency or eye or tissue bank for transplantation or other therapy
- ☐ the following university, hospital, storage bank, or other medical institution:_____

_____

_____

**for:** (*MARK ALL THAT APPLY*)

- ☐ transplantation or treatment of any person who can medically benefit
- ☐ medical education
- ☐ medical research
- ☐ any purpose authorized by law

## PART 2: INDIVIDUAL HEALTH CARE INSTRUCTION (*OPTIONAL*)

### End-of-Life Decisions

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, then:

(*MARK ONLY ONE*)

☐ I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

☐ I direct that treatment for alleviation of pain and discomfort be provided at all times, even if it hastens my death, and I direct that artificial nutrition (food) and hydration (water) be provided, but otherwise I do not want my life to be prolonged and I do not authorize active treatment for my medical conditions.

☐ I direct that treatment for alleviation of pain and discomfort be provided at all times, even if it hastens my death, but otherwise I do not want my life to be prolonged and I do not authorize artificial nutrition (food) and hydration (water) or any other active treatment for my medical conditions.

### Other Wishes

I direct that: (*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*.)

_____

_____

_____

_____

_____

_____

_____

_____

_____

☐ Additional sheets attached. (*MARK ONLY IF APPLICABLE*)

## PART 3: MISCELLANEOUS PROVISIONS AND EXECUTION

### Prior Directives Revoked

I revoke any previously-executed Power of Attorney for Health Care, Individual Health Care Instruction, or Natural Death Act Declaration.

### Copies

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

### Signature of Principal

I sign my name to and acknowledge this Advance Health Care Directive:

_____ _____ _____

*Signature* *Date of Birth* *Date of Signing*

## Statement of Witnesses

I declare under penalty of perjury under the laws of California (1) that the individual who signed or acknowledged this advance health care directive is personally known to me, or that the individual's identity was proven to me by convincing evidence, (2) that the individual signed or acknowledged this advance health care directive in my presence, (3) that the individual appears to be of sound mind and under no duress, fraud, or undue influence, (4) that I am not a person appointed as agent by this advance health care directive, and (5) that 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, an employee of an operator of a community care facility, the operator of a residential care facility for the elderly, nor an employee of an operator of a residential care facility for the elderly.

**First Witness:** _____ _____
*Signature* *Name Printed*

_____ _____
*Date* *Residence Address*

**Second Witness:** _____ _____
*Signature* *Name Printed*

_____ _____
*Date* *Residence Address*

## Special Witness Requirement

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 entitled to any part of the individual's estate upon his or her death under a will now existing or by operation of law.

_____ _____
*Signature* *Date*

## 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 am serving as a witness as required by Probate Code 4675.

_____ _____
*Name/Title Printed* *Signature*

_____ _____
*Date* *Address*

## Certificate of Acknowledgement of Notary Public

STATE OF CALIFORNIA )
) ss.
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 Public*