ADVANCED HEALTHCARE DIRECTIVE FOR

_____

(Print Name Here)

Part 1 of this form 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 an employee of the health care institution where you are receiving care, unless your agent is related to you or is a coworker.

Unless you state otherwise in this form, 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. Donate organs, tissue or parts, authorize an autopsy, and direct disposition of remains.

However, your agent will not be able to commit you to a mental health facility, or consent to convulsive treatment or psychosurgery for you.

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. You also can add to the choices you have made or write down 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.

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

Name of individual I choose as agent: _____

Address: _____

_____

Telephone: _____
(home) (cell)

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 the following alternate agents:

Name of individual I choose as first alternate agent: _____

Address: _____

_____

Telephone: _____
(home) (cell)

Name of individual I choose as second alternate agent: _____

Address: _____

_____

Telephone: _____
(home) (cell)

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.

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.

_____
(Initial here)

OR

My agent's authority to make health care decisions for me takes effect immediately. _____
(Initial here)

***AGENT'S POSTDEATH AUTHORITY*:** My agent is authorized to donate my organs, tissues and parts, authorize an autopsy and direct disposition of my remains, except as I state here or in Part 4 of this form: (Initial choice)

I wish to be cremated _____ I wish to be buried _____ I am not sure _____

Other Instructions: _____

PART 2 – INSTRUCTIONS FOR HEALTH CARE

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:

Choice *Not To* Prolong Life:

_____ (Initial here) 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:

_____ (Initial here) I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

RELIEF FROM PAIN: I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death.

PART 3 – PRIMARY PHYSICIAN (OPTIONAL)

I designate the following physician as my primary physician:

Name: _____

Address: _____

Telephone: _____ Fax: _____

_____ Initial here if you would like your Advanced Healthcare Directive faxed to the physician.

PART 4 – DONATION OF ORGANS, TISSUES AND PARTS AT DEATH (OPTIONAL)

I. Upon my death (Initial one):

_____ I give my organs, tissues and parts as anatomical gifts. By initialing here 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 donation is for the following purposes (strike any of the following you do not want): Transplant; Therapy; Research; Education.

_____ I **do not** want to donate my organs. If you 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.

INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY PHYSICAL OR MENTAL HEALTH: I grant to my agents under this advance health care directive the authority to advocate for my health care needs if I have been determined to lack capacity to make my own Health Care Decisions.

Pursuant to 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 (Civil Code §§56-56.37), I authorize all health care providers and covered entities to disclose to my agent and alternate agents under this Advance Health Care Directive, to my current attorney, to the trustee of any trust of which I am a beneficiary all of, and to my agent in any durable power of attorney, my individually identifiable health and medical information and medical records regarding any past, present, or future medical or mental health condition in the minimum amount necessary to advocate for my health care needs.

I intend my agent to be dealt with by all my health care providers and covered entities, as required by **HIPAA** and California law, in the 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.

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 3 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.

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.

ADDITIONAL WISHES: In addition to my direction in this form, I have the following additional wishes: _____

_____

_____

PART 5 – SIGNATURE

SIGNATURE:

Date: _____ Signature: _____

Print 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 Ventura)

On _____, 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.

Signature of Notary:

_____

OR

STATEMENT OF WITNESSES

I declare under penalty of perjury under the laws of the State of California: (1) that the individual who signed or acknowledged this advanced 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 advanced 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 advanced 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	SECOND WITNESS
Signature:	Date:	Date:
Print Name:		
Address:		
Telephone:		

ADDITIONAL STATEMENT OF WITNESSES

At least one of the above witnesses must also sign the following declaration:

I further declare under penalty of perjury under the laws of the State of California that I am not related to the individual executing this advanced 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.

Date: _____ Time: _____ a.m. / p.m.

Signature: _____ Print Name: _____

(Health and Safety Code Section 7158.3)
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