COMBINED ADVANCE DIRECTIVE

Principal: [YOUR FULL LEGAL NAME] **Date of Birth:** **Address:** [YOUR ADDRESS] **State of Residence:** [STATE] **Effective Date:**

Notice to the Principal

> ***THIS IS AN IMPORTANT LEGAL DOCUMENT.*** *Before signing this Advance Healthcare Directive, you should read it carefully and understand its consequences. This document gives the person you designate as your Agent broad powers to make healthcare decisions for you, including the power to consent to or refuse medical treatment, to direct the withholding or withdrawal of life-sustaining treatment, and to authorize an autopsy and the donation of your organs. These powers take effect only when you are unable to make healthcare decisions for yourself, unless you specify otherwise. You have the right to revoke this Directive at any time.*

Article I. Designation of Healthcare Agent

I, **[YOUR FULL LEGAL NAME]**, being of sound mind and at least eighteen (18) years of age, hereby designate the following person as my healthcare agent ("Agent") with authority to make healthcare decisions for me when I am unable to do so:

Primary Agent: [PRIMARY AGENT S FULL LEGAL NAME] **Relationship:** [AGENT S RELATIONSHIP TO YOU] **Address:** [AGENT S ADDRESS] **Telephone:** [AGENT S PHONE NUMBER]

Alternate Agent

If my primary Agent is unavailable, unwilling, or unable to serve, I designate the following person as my alternate (successor) Agent, with the same authority and responsibilities:

Alternate Agent: Relationship: Address: Telephone:

Article II. Scope of Agent Authority

My Agent shall have **full authority** to make any and all healthcare decisions for me that I could make if I had capacity, including without limitation the power to:

(a) consent to, refuse, or withdraw consent to any medical care, treatment, service, or procedure, including life-sustaining treatment; (b) select, employ, and discharge healthcare providers, institutions, and facilities; (c) access, review, receive, and authorize the release of my medical records and other protected health information under HIPAA (45 C.F.R. Parts 160 and 164) and state law; (d) admit me to or discharge me from any hospital, hospice, nursing home, residential care, or assisted-living facility; (e) apply for

public or private benefits on my behalf to pay for healthcare; (f) authorize pain management, palliative care, and hospice services; (g) make anatomical gifts and authorize autopsy; (h) exercise my rights under this Directive and under applicable law.

Article III. When Agent Authority Takes Effect

My Agent's authority shall become effective only upon a determination, made in writing by my attending physician (or two physicians where required by the law of [STATE]), that I lack the capacity to make or communicate my own healthcare decisions. My Agent's authority shall cease when I regain such capacity.

Article IV. End-of-Life Treatment Instructions (Living Will)

The following instructions shall guide my Agent and my healthcare providers. I intend these instructions to constitute **clear and convincing evidence** of my wishes for purposes of any applicable evidentiary standard.

A. General Preference

If I am in a terminal condition, permanently unconscious, or in an end-stage condition from which there is no reasonable expectation of recovery, I direct that **life-prolonging treatment be withheld or withdrawn**, and that I be permitted to die naturally with only such treatment as is necessary to provide comfort and to alleviate pain.

B. Specific Conditions

Condition	My Direction
Terminal condition (incurable, death expected soon)	Withhold/withdraw life-sustaining treatment
Permanent coma or persistent vegetative state	Withhold/withdraw life-sustaining treatment
End-stage condition (advanced, progressive, irreversible)	Withhold/withdraw life-sustaining treatment

C. Artificial Nutrition and Hydration

Artificial nutrition (tube feeding): I direct that artificial nutrition be **withheld** when other life-sustaining treatment is withheld under this Directive.

Artificial hydration (IV fluids): I direct that artificial hydration be **withheld** when other life-sustaining treatment is withheld under this Directive.

I understand that artificial nutrition and hydration, though invasive, may be considered medical treatment that can be refused. I have considered this decision carefully.

D. Pain Management

I direct that I receive **maximum pain relief and palliative care**, including medications that may have the secondary effect of hastening my death, consistent with the doctrine of double effect. My comfort and dignity are of paramount importance.

E. Specific Treatments I Refuse (under end-of-life conditions)

If I am in a terminal, permanently unconscious, or end-stage condition, I specifically **refuse** the following treatments:

- Cpr
- Mechanical Ventilation

F. Additional Personal Instructions

None stated.

Article V. Anatomical Gift (Organ and Tissue Donation)

Upon my death, I make the following anatomical gift pursuant to the Uniform Anatomical Gift Act (as enacted in [STATE]):

I give **any needed organs, tissues, or parts** of my body.

Purposes permitted: Transplant; Therapy; Research; Education.

Article VI. HIPAA Release

I intend for my Agent to be treated as a "personal representative" under the HIPAA Privacy Rule (45 C.F.R. § 164.502(g)), with full authority to receive and use protected health information about me for purposes of exercising the powers granted in this Directive. I authorize any covered entity to release to my Agent any and all protected health information, including records protected under 42 C.F.R. Part 2 (substance-use disorder) and state laws governing mental health, HIV/AIDS, and genetic information.

Article VIII. Admonition to Providers

Any healthcare provider, facility, or payor relying on this Directive in good faith shall be held harmless from civil or criminal liability to the fullest extent permitted by law. A provider who is unwilling to comply with this Directive for reasons of conscience must promptly so inform my Agent and must transfer my care to a provider who will comply.

Article IX. Revocation

I reserve the right to revoke or amend this Directive at any time, orally or in writing, in any manner that communicates my intent to revoke. Revocation shall be effective upon communication to my attending physician or to my Agent.

Article X. Governing Law and Reciprocity

This Directive shall be construed under the laws of the State of [STATE]. I intend that this Directive be given full effect in any jurisdiction in which I may be located at the time of treatment, to the maximum extent permitted by that jurisdiction's advance-directive-reciprocity statute or common law.

Article XI. Execution and Acknowledgment by Principal

I sign this Advance Healthcare Directive voluntarily, after careful reflection, with full understanding of its contents and legal effect. I am of sound mind and am at least eighteen (18) years of age.

Principal

________________________________ PRINTED NAME

________________________________ SIGNATURE

________________________________ DATE

Article XII. Witnesses

Witness Declarations. Each witness, by signing below, declares under penalty of perjury under the laws of the State of [STATE] that: (a) the Principal is personally known to the witness, or has provided satisfactory evidence of identity; (b) the Principal signed or acknowledged this Directive in the witness's presence; (c) the Principal appears to be of sound mind and under no duress, fraud, or undue influence; (d) the witness is at least 18 years of age; (e) the witness is **not** the Agent or alternate Agent designated herein; (f) the witness is **not** the Principal's healthcare provider or an employee of the Principal's healthcare provider; (g) the witness is **not** an operator or employee of a community-care facility, residential-care facility, or skilled-nursing facility at which the Principal receives care; and (h) the witness is not entitled to any portion of the Principal's estate upon the Principal's death under a will, trust, or the laws of intestacy (where state law so requires).

Witness 1: [FIRST WITNESS S FULL NAME] Address:

Witness 1

________________________________ PRINTED NAME

________________________________ SIGNATURE

________________________________ DATE

Notary Acknowledgment

State of [STATE] County of _____

On this _____ day of _____**, 20**, before me, the undersigned notary public, personally appeared **[YOUR FULL LEGAL NAME]**, proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to this instrument, and acknowledged to me that he/she executed the same voluntarily, for the purposes therein stated, and that he/she is of sound mind.

I certify under PENALTY OF PERJURY under the laws of the State of [STATE] that the foregoing is true and correct.

Notary Public: _____ My commission expires: _____
[NOTARY SEAL]