

COMBINED LIVING WILL AND ADVANCE HEALTHCARE DIRECTIVE

State of Execution: [STATE] **Effective Date:**

I, [DECLARANT NAME], born , residing at [DECLARANT ADDRESS] (the "Declarant," "Principal," or "Patient"), being of sound mind and at least eighteen (18) years of age, voluntarily make this **Combined Advance Healthcare Directive** — comprising a **Living Will** (statement of treatment wishes) and a **Healthcare Power of Attorney** (appointment of a healthcare agent) — under the laws of the State of [STATE], as a directive to physicians, my healthcare agent, family members, and all other persons concerned with my care.

1. Statement of Capacity and Voluntariness

I am competent to make this directive. I understand its contents and legal effect. I am not acting under duress, fraud, or undue influence. I make this directive freely and voluntarily, after reflection on the medical, personal, moral, and (where applicable) religious implications of the choices expressed herein.

2. Appointment of Healthcare Agent

I hereby appoint the following person as my Healthcare Agent (the "Agent") to make healthcare decisions for me if I lose the capacity to make them myself:

- **Name:** [PRIMARY AGENT FULL LEGAL NAME]
- **Relationship:** [RELATIONSHIP TO YOU]
- **Address:** [PRIMARY AGENT ADDRESS]
- **Phone:** [PRIMARY AGENT PHONE]

When authority begins. My Agent's authority begins when a physician determines in writing that I lack the capacity to make or communicate my own healthcare decisions, and ends when I regain capacity.

Scope of authority. My Agent has full authority to make all healthcare decisions I could make if I had capacity, including (without limitation): consenting to, refusing, or withdrawing any medical treatment, service, or procedure; selecting, hiring, and discharging physicians, nurses, therapists, and facilities; authorizing or refusing artificial nutrition, hydration, and life-sustaining treatment (consistent with any explicit instructions in this directive); accessing, copying, and disclosing my medical records; making decisions about pain management, palliative sedation, hospice, and comfort care; admitting me to or discharging me from hospitals, nursing homes, assisted-living facilities, and hospice programs; authorizing an autopsy; directing disposition of my remains; and making an anatomical gift of my body or parts thereof consistent with any instruction below.

Agent obligation. My Agent shall make decisions consistent with my wishes as stated in this directive. Where my wishes are unknown or do not clearly address a specific circumstance, my Agent shall act in my best interest after consulting with my attending physician and weighing the burdens and benefits of treatment.

Ineligible persons. My Agent is not my attending physician, an employee of my attending physician, or an owner/operator/employee of a residential healthcare facility where I reside (unless related to me by blood, marriage, or adoption).

Nomination of guardian/conservator. If a court proceeding is ever initiated to appoint a guardian or conservator of my person, I nominate my Agent (and the alternates, in order) to serve in that capacity, to the maximum extent permitted by law.

3. Statement of Treatment Wishes (Living Will)

Overall philosophy. If I am in one of the conditions described below and my attending physician determines my condition is incurable and irreversible, I direct that life-sustaining treatment be **withheld or withdrawn** and that I be permitted to die naturally, receiving only comfort care.

Conditions under which this directive applies. This directive takes effect if I am unable to make or communicate healthcare decisions and my attending physician (or, where required, two physicians) determines that I am in any of the following conditions:

- **Terminal condition** — an incurable and irreversible illness or injury from which, in the opinion of my attending physician, death is expected within a relatively short time without the use of life-sustaining treatment.
- **Persistent vegetative state** — a state of permanent unconsciousness with no reasonable medical probability of regaining awareness or higher brain function.
- **End-stage condition** — an advanced, progressive, and incurable condition that has caused severe and permanent deterioration evidenced by loss of capacity and complete physical dependency, for which treatment would be medically ineffective.

Specific Treatment Instructions

Artificial Nutrition and Hydration (feeding tubes, IV fluids) — initial _____. I want artificial nutrition and hydration **withheld or withdrawn**, even if their withdrawal may result in my death. I have considered this instruction carefully in light of the Supreme Court's decision in *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261 (1990), which requires clear and convincing evidence of a patient's wishes on this subject.

Cardiopulmonary Resuscitation (CPR). I do **not** want CPR attempted. I request that my physician enter a Do Not Resuscitate (DNR) order in my medical record consistent with this wish.

Mechanical Ventilation. I do **not** want mechanical ventilation.

Dialysis. My Agent may decide about dialysis.

Antibiotics. My Agent may decide about antibiotics.

Blood Transfusions. I want blood transfusions provided as medically indicated.

Comfort care and pain management. Regardless of any other instruction in this directive, I want to be kept as free of pain and suffering as possible. I authorize the administration of medication, including opioids, in doses sufficient to control pain and suffering even if such medication may hasten my death (the doctrine of double effect). I want dignity, personal hygiene, oral care, and a calm environment maintained to the extent reasonably possible.

Hospice. I authorize my Agent and my physicians to enroll me in hospice care when my condition warrants, and to accept the hospice philosophy of comfort-focused care.

Important: DNR and POLST Are Physician Orders

The wishes expressed above are my patient declarations. A **Do Not Resuscitate (DNR) order** and a **Physician Orders for Life-Sustaining Treatment (POLST / MOLST / POST) form** are separate medical orders that must be signed by a physician and entered in my medical record to be operative on emergency responders and hospital staff. I (or my Agent) shall request that my attending physician issue a DNR order and, if appropriate, a POLST/MOLST/POST consistent with this directive.

4. Pregnancy

The pregnancy provisions of this directive are not applicable to me.

5. HIPAA Authorization (45 CFR §164.508)

I intend for my Agent to be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information and other medical records. This authorization applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. §1320d et seq., and 45 CFR §§160–164. I specifically authorize any physician, healthcare professional, hospital, clinic, pharmacy, laboratory, ambulance service, long-term-care facility, health plan, insurer, or other covered entity to disclose to my Agent any and all of my protected health information (PHI), including records related to HIV/AIDS, mental health, drug/alcohol treatment, and genetic information, to the extent permitted by applicable law. This authorization has no expiration date and survives my incapacity; it may be revoked by me in writing.

9. Preferred Setting for Care

I express no specific preference regarding care setting; my Agent and care team may decide based on the circumstances.

11. Revocation

I may revoke this directive at any time and in any manner that communicates my intent to revoke, regardless of my mental or physical condition. Methods of revocation include: (a) a signed and dated written revocation; (b) physical destruction of this directive with intent to revoke; (c) an oral statement of revocation made to my Agent or to a healthcare provider; or (d) the execution of a subsequent directive that, in whole or in part, supersedes this one.

12. Effect of Copy

A copy of this executed directive has the same force and effect as the signed original. I authorize my Agent, physicians, hospitals, and family members to rely on a photocopy, scan, facsimile, or electronic copy of this document.

13. Severability and Governing Law

If any provision of this directive is held invalid or unenforceable, the remaining provisions shall continue in full force and effect. This directive shall be governed by the laws of the State of [STATE], provided that it shall also be given effect in any other jurisdiction to the extent permitted by that jurisdiction's law.

Patient Self-Determination Act Notice

Under the federal Patient Self-Determination Act of 1990 (42 U.S.C. §§1395cc(f), 1396a(w)), hospitals, nursing homes, home health agencies, hospices, and HMOs participating in Medicare or Medicaid are required to ask adult patients whether they have an advance directive, to provide information about advance directives, and to not discriminate in care based on the existence or non-existence of a directive.

Signature of Declarant

I sign this directive knowingly, voluntarily, and after careful consideration.

Declarant

PRINTED NAME

SIGNATURE

DATE

Distribution

This directive shall be distributed to, at minimum: (a) my primary-care physician; (b) my healthcare Agent and any alternate Agents; (c) the hospital or healthcare facility where I typically receive care; (d) close family members; and (e) if applicable, my state's advance-directive registry.