ADVANCE HEALTH CARE DIRECTIVE
CALIFORNIA POWER OF ATTORNEY FOR HEALTH CARE
(Appointing an Agent to Make Health Care Decisions)

Sample

NOTE: COMPLETION OF THIS FORM IS ONLY THE FIRST STEP. YOU SHOULD DISCUSS YOUR WISHES IN DETAIL WITH YOUR DESIGNATED AGENT(S).

My name is:

____

My address is:

____

In this document, I appoint one or more agents to make health care decisions for me. My agent's authority shall begin immediately, even though I currently have the mental capacity to make my own health care decisions.

AGENT

Name: ______________________________

Address: ______________________________ Home Phone: ______________________________

______________________________ Work Phone: ______________________________

1ST ALTERNATE AGENT (If Agent is unavailable or unwilling to serve.)

Name: ______________________________

Address: ______________________________ Home Phone: ______________________________

______________________________ Work Phone: ______________________________

2ND ALTERNATE AGENT (If Agent and 1ST Alternate Agent are unavailable or unwilling to serve.)

Name: ______________________________

Address: ______________________________ Home Phone: ______________________________

______________________________ Work Phone: ______________________________

AGENT'S AUTHORITY
Except as limited by this document, my agent will have authority to make 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 1) to accept or refuse treatment, nutrition and hydration, 2) to choose a particular physician or health care facility, and 3) to receive, or consent to the release of, medical information and records. If I have the mental capacity to make my own health care decisions, my agent shall not have the authority to make any health care decision with which I disagree.

Except as limited by this document, this authority includes the authority to authorize an autopsy, donate all or part of my body, and/or determine the disposition of my remains.

AGENT'S DUTIES
My agent shall make decisions for me in accordance with this power of attorney for health care, any written instructions I have provided to my agent and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make 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.

HEALTH CARE INSTRUCTIONS (OPTIONAL)
I make the following instructions to my agent:
(Attach additional pages if necessary. Sign and date any additional pages on the same day you sign this document, and state the number of attached pages here: ( ) pages.

AUTHORITY UNDER HIPAA AND CMIA
My agent shall be a personal representative of mine under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). As such, my agent has the same rights to inspect and obtain copies of any medical or other health information as I would have. My agent also has the right to authorize disclosure of my patient records and other medical or health information subject to and protected under HIPAA. Pursuant to the California Confidentiality of Medical Information Act (CMIA) and Section 4678 of the California Probate Code, my agent has the same rights to request, receive, examine, copy and consent to the disclosure of my medical or other health care information as I would have.

The above authority applies to any individually identifiable health or medical information, health care information or other medical records governed by HIPAA, CMIA or Section 4678 of the California Probate Code.

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 designate above.

PERSONAL CARE DECISIONS
I authorize my agent to make decisions regarding my personal care, including decisions regarding where I will live, hiring household employees, furnishing transportation and meals, handling my mail and arranging recreation and entertainment on my behalf. If I initial here ______, I do not want my agent to have the authority provided by the preceding sentence.

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 initialed below:

(a) Choice Not To Prolong Life. 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, initial here ______; OR,

(b) Choice To Prolong Life. I want my life to be prolonged as long as possible within the limits of generally accepted health care standards, initial here ______.

RELIEF FROM PAIN: Except as I state in the following space, I direct that treatment for alleviation of pain

Sample

or discomfort be provided at all times, even if it hastens my death:

____

____

____.

DISAGREEMENT WITH OTHER AGENTS
In case of disagreement between my agent and an agent under any financial or other power of attorney of mine regarding payment for my health and/or personal care or regarding any other matters addressed under this power of attorney for health care, the decision of my agent under this power of attorney for health care shall control. If I initial here ______, I do not want my agent to have the authority provided by the preceding sentence.

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

SIGNATURE OF PRINCIPAL (PERSON APPOINTING THE AGENT)

Date: _________________ Signature: _____________________________________

(If principal is not physically able to sign, he or she can instruct another person to sign the principal's name, if signature is done in the principal's presence.)

WITNESSES
This document must either be notarized or signed by two adult witnesses. If the principal (the person appointing the agent) currently resides in a nursing facility, this document also must be witnessed by a patient advocate or ombudsman designated by the California Department of Aging. If the two-witness method is chosen, the patient advocate or ombudsman may serve as one of the two witnesses, or may serve as a third witness. If the notarization method is chosen, the patient advocate or ombudsman serves as a separate witness.

Certain individuals cannot serve as witnesses. Those rules are set forth in the following witness statements.

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 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 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.

Sample

First Witness: ______________________________Signature

Name (printed) ____________________________

Date: __________ Address: ____

Second Witness: ______________________________Signature

Name (printed) ____________________________

Date: __________ Address: ____

ONE OF THE PRECEDING WITNESSES ALSO MUST SIGN THE FOLLOWING DECLARATION:
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.

Date: _______________ Signature: ___________________________

DECLARATION OF PATIENT ADVOCATE OR OMBUDSMAN
(Required if person appointing the agent currently resides in a nursing facility)
I declare under penalty of perjury under the laws of California that I am a patient advocate or ombudsman designated by the California Department of Aging and that I am serving as a witness as required by Section 4675 of the California Probate Code.

Date: _______________ Signature: ___________________________

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC (Not required if two-witness method is followed) State of California, County of

On thisday of,____________________, before me, the undersigned, a Notary Public in and for said State, personally appeared____, personally known to me or 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 it.

WITNESS my hand and official seal.

Signature:___________________________ (seal)

Sample