PART II: DURABLE HEALTH CARE POWER OF ATTORNEY

PRINT YOUR NAME AND COUNTY

I,____, of

______________________________ County, Pennsylvania, appoint the person named below to be my health care agent to make health and personal care decisions for me.

Effective immediately and continuously until my death or revocation by a writing signed by me or someone authorized to make health care treatment decisions for me, I authorize all health care providers or other covered entities to disclose to my health care agent, upon my agent's request, any information, oral or written, regarding my physical or mental health, including, but not limited to, medical and hospital records and what is otherwise private, privileged, protected or personal health information, such as health information as defined and described in the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191, 110 Stat. 1936), the regulations promulgated there under and any other State or local laws and rules. Information disclosed by a health care provider or other covered entity may be redisclosed and may no longer be subject to the privacy rules provided by 45 C.F.R. Pt. 164.

The remainder of this document will take effect when and only when I lack the ability to understand, make or communicate a choice regarding a health or personal care decision as verified by my attending physician. My health care agent may not delegate the authority to make decisions.

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CROSS OUT AND INITIAL POWERS YOU DO NOT WANT YOUR AGENT TO HAVE

MY HEALTH CARE AGENT HAS ALL OF THE FOLLOWING POWERS, SUBJECT TO ANY HEALTH CARE TREATMENT INSTRUCTIONS THAT I GIVE IN THIS DOCUMENT (CROSS OUT AND INITIAL ANY POWERS YOU DO NOT WANT TO GIVE YOUR HEALTH CARE AGENT):

1. To authorize, withhold or withdraw medical care and surgical procedures.

2. To authorize, withhold or withdraw nutrition (food) or hydration (water) medically supplied by tube through my nose, stomach, intestines, arteries or veins.

3. To authorize my admission to or discharge from a medical, nursing, residential or similar facility and to make agreements for my care and health insurance for my care, including hospice and/or palliative care.

4. To hire and fire medical, social service and other support personnel responsible for my care.

5. To take any legal action necessary to do what I have directed.

6. To request that a physician responsible for my care issue a do-not-resuscitate (DNR) order, including an out-of-hospital DNR order, and sign any required documents and consents.

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PRINT THE NAME, RELATIONSHIP AND ADDRESS OF YOUR AGENT

PRINT PHONE NUMBER AND EMAIL ADDRESS OF YOUR AGENT

PRINT THE NAME, RELATIONSHIP, ADDRESS, PHONE NUMBER AND EMAIL ADDRESS OF YOUR ALTERNATE HEALTH CARE AGENTS

APPOINTMENT OF HEALTH CARE AGENT

I appoint the following health care agent:

Health care agent:

____
(Name and relationship)

Address: ____

____

Telephone Number: Home________________ Work________________

E-mail: ____

IF YOU DO NOT NAME A HEALTH CARE AGENT, HEALTH CARE PROVIDERS WILL ASK YOUR FAMILY OR AN ADULT WHO KNOWS YOUR PREFERENCES AND VALUES FOR HELP IN DETERMINING YOUR WISHES FOR TREATMENT.

NOTE THAT YOU MAY NOT APPOINT YOUR DOCTOR OR OTHER HEALTH CARE PROVIDER AS YOUR HEALTH CARE AGENT UNLESS RELATED TO YOU BY BLOOD, MARRIAGE OR ADOPTION.

If my health care agent is not readily available or if my health care agent is my spouse and an action for divorce is filed by either of us after the date of this document, I appoint the person or persons named below in the order named. (It is helpful, but not required, to name alternative health care agents.)

First Alternative Health Care Agent:

____
(Name and relationship)

Address: ____

____

Telephone Number: Home________________ Work________________

E-mail: ____

Second Alternative Health Care Agent:

____
(Name and relationship)

Address: ____

____

Telephone Number: Home________________ Work________________

E-mail: ____

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ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES, IF NEEDED

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GUIDANCE FOR HEALTH CARE AGENT (OPTIONAL)

When making health care decisions for me, my health care agent should think about what action would be consistent with past conversations we have had, my treatment preferences as expressed in this or any other document, my religious and other beliefs and values, and how I have handled medical and other important issues in the past. If what I would decide is still unclear, then my health care agent should make decisions for me that my health care agent believes are in my best interest, considering the benefits, burdens, and risks of my current circumstances and treatment options.

I offer the following instructions as additional guidance to my health care agent:

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(Attach additional pages, if needed.)

PART III: LIVING WILL

LIVING WILL INFORMATION

The following health care treatment instructions exercise my right to make my own health care decisions. These instructions are intended to provide clear and convincing evidence of my wishes to be followed when I lack the capacity to understand, make or communicate my treatment decisions:

IF I HAVE AN END-STAGE MEDICAL CONDITION (WHICH WILL RESULT IN MY DEATH, DESPITE THE INTRODUCTION OR CONTINUATION OF MEDICAL TREATMENT) OR AM PERMANENTLY UNCONSCIOUS SUCH AS AN IRREVERSIBLE COMA OR AN IRREVERSIBLE VEGETATIVE STATE AND THERE IS NO REALISTIC HOPE OF SIGNIFICANT RECOVERY, ALL OF THE FOLLOWING APPLY (CROSS OUT ANY TREATMENT INSTRUCTIONS WITH WHICH YOU DO NOT AGREE):

CROSS OUT ANY TREATMENT INSTRUCTIONS WITH WHICH YOU DISAGREE

1. I direct that I be given health care treatment to relieve pain or provide comfort even if such treatment might shorten my life, suppress my appetite or my breathing, or be habit forming.

2. I direct that all life prolonging procedures be withheld or withdrawn.

3. I specifically do not want any of the following as life prolonging procedures: (If you wish to receive any of these treatments, write "I do want" after the treatment)

WRITE "I DO WANT" IF YOU WISH TO RECEIVE THESE TREATMENTS

heart-lung resuscitation (CPR) No

mechanical ventilator (breathing machine) No

dialysis (kidney machine) No

surgery No

chemotherapy No

radiation treatment No

antibiotics No

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Please indicate whether you want nutrition (food) or hydration (water) medically supplied by a tube into your nose, stomach, intestine, arteries, or veins if you have an end-stage medical condition or are permanently unconscious and there is no realistic hope of significant recovery.

TUBE FEEDINGS

INITIAL ONLY ONE

_____I want tube feedings to be given

OR

__X__I do not want tube feedings to be given.

HEALTH CARE AGENT'S USE OF INSTRUCTIONS

INITIAL ONLY ONE

_____My health care agent must follow these instructions.

OR

_____These instructions are only guidance. My health care agent shall have final say and may override any of my instructions. (Indicate any exceptions here):______________________________
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____

If I have not appointed a health care agent, these instructions shall be followed.

LEGAL PROTECTION

Pennsylvania law protects my health care agent and health care providers from any legal liability for their good faith actions in following my wishes as expressed in this form or in complying with my health care agent's direction. On behalf of myself, my executors and heirs, I further hold my health care agent and my health care providers harmless and indemnify them against any claim for their good faith actions in recognizing my health care agent's authority or in following my treatment instructions.

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ORGAN DONATION

INITIAL ONLY ONE

ORGAN DONATION (INITIAL ONE OPTION ONLY)

_______ I consent to donate my organs and tissues at the time of my death for the purpose of transplant, medical study or education. (Insert any limitations you desire on donation of specific organs or tissues or uses for donation of organs and tissues.)

OR

_______ I do not consent to donate my organs or tissues at the time of my death.

If I have consented to donate my organs and tissues, I place the following limitation on my donation: (Insert any limitations you desire on donation of specific organs or tissues or uses for donation of organs and tissues.)

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PRINT YOUR NAME AND THE DATE AND SIGN HERE

PART IV: SIGNATURE

I, ____ (print your name), having carefully read this document, have signed it this _____ day of ____________, 20_____, revoking all previous health care powers of attorney and health care treatment instructions.

____
(SIGN FULL NAME HERE FOR HEALTH CARE POWER OF ATTORNEY AND HEALTH CARE TREATMENT INSTRUCTIONS)

YOUR TWO WITNESSES MUST SIGN AND DATE AND PRINT THEIR NAMES HERE

WITNESS SIGNATURE: __________________________ Date: _______

Printed name: _________________________________

WITNESS SIGNATURE: __________________________ Date: _______

Printed name: _________________________________

Two witnesses at least 18 years of age are required by Pennsylvania law and should witness your signature in each other's presence. A person who signs this document on behalf of and at the direction of a principal may not be a witness. (It is preferable if the witnesses are not your heirs, nor your creditors, nor employed by any of your health care providers.)

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You Have Filled Out Your Health Care Directive, Now What?

1. Your Pennsylvania Advance Health Care Directive is an important legal document. Keep the original signed document in a secure but accessible place. Do not put the original document in a safe deposit box or any other security box that would keep others from having access to it.

2. Give photocopies of the signed original to your health care agent and alternate health care agent(s), doctor(s), family, close friends, clergy, and anyone else who might become involved in your health care. If you enter a nursing home or hospital, have photocopies of your document placed in your medical records.

3. Be sure to talk to your health care agent(s), doctor(s), clergy, family, and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.

4. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

5. If you want to make changes to your documents after they have been signed and witnessed, you must complete a new document.

6. Remember, you can always revoke your Pennsylvania document.

7. Be aware that your Pennsylvania document will not be effective in the event of a medical emergency. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate directive that states otherwise. These directives called "prehospital medical care directives" or "do not resuscitate orders" are designed for people whose poor health gives them little chance of benefiting from CPR. These directives instruct ambulance and hospital emergency personnel not to attempt CPR if your heart or breathing should stop.

   Currently not all states have laws authorizing these orders. We suggest you speak to your physician if you are interested in obtaining one. **CaringInfo does not distribute these forms.**