ADVANCE HEALTHCARE DIRECTIVE

SECTION 1 — HEALTHCARE POWER OF ATTORNEY

I,_____, of _____County, Pennsylvania, appoint the person named below to be my Healthcare Agent to make health and personal care decisions for me whenever I cannot understand, make or communicate a choice regarding a healthcare decision, as determined by my doctor, unless I give my Healthcare Agent immediate authority to make health and personal decisions in this document. My agent may not delegate the authority to make decisions.

APPOINTMENT OF HEALTHCARE AGENT:

I appoint the following as my Healthcare Agent: *You may not appoint your doctor or other healthcare provider as your Healthcare Agent unless related to you by blood, marriage or adoption.*

Healthcare Agent: _____
(Name and Relationship)

Address:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Email:_____

If my Healthcare Agent is not able or not willing to act in a timely manner, or if my Healthcare 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 Healthcare Agents).

Alternative Healthcare Agent: _____
(Name and Relationship)

Address:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Email:_____

Your signature and two witness signatures are also required at the end of this document – See Section 5.

SEPARATE HIPAA PRIVACY AUTHORIZATION EFFECTIVE IMMEDIATELY (Optional)

Effective immediately and continuously until my death or revocation by a writing signed by me or someone authorized to make healthcare treatment decisions for me, I authorize all healthcare providers or other covered entities to disclose to my Healthcare 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 any other 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 ("HIPAA"), the regulations issued under HIPAA and any other State or local laws and rules. Information disclosed by a healthcare provider or other covered entity may be redisclosed and may no longer be subject to these privacy rules.

Signature: _____ Date:_____

** Even without this HIPAA waiver, HIPAA may still allow your doctor to share your information as necessary for treatment. **

ADVANCE HEALTHCARE DIRECTIVE

SECTION 2 — HEALTHCARE AGENT POWERS

My Healthcare Agent has all of the following powers subject to the healthcare treatment instructions that follow in SECTION 3. (Cross out any powers you do not want to give your Healthcare 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 obtain 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 request that a physician responsible for my care issue a do-not-resuscitate (DNR) order, including an out-of-hospital DNR order, a Physician Order for Life-Sustaining Treatment (POLST) or other order to carry out my wishes and to sign any required documents and consents.
6. To carry out my wishes regarding funeral, burial, and the disposition of my body.
7. To take any legal action necessary to do what I have directed.
8. To authorize or refuse to authorize donation of organs (for example, heart, lung, liver, kidney), tissue, eyes, or other parts of the body.
9. To authorize or refuse to authorize donation of hands, facial tissue, limbs, or other vascularized composite allografts.

The powers listed above shall apply to both physical and mental health care as defined under Section 5422 of the Probate, Estates and Fiduciaries Code. I do not have a mental healthcare power of attorney or declaration under Chapter 58 of the Probate, Estates and Fiduciaries Code. (Modify or use a different form as needed if you have a mental healthcare power of attorney or declaration)

I nominate my Healthcare Agent as the guardian of my person, should such a guardian be necessary.

HEALTHCARE AGENT AUTHORITY. My Healthcare Agent shall have authority to make health and personal decisions for me: (Initial one option only)

Initials: _____ Only whenever I cannot understand, make or communicate a choice as determined by my doctor.

OR

Initials: _____ Immediately upon my signing of this document.

GUIDANCE FOR HEALTHCARE AGENT (Optional)

Goals: If I have an end stage medical condition or other extreme irreversible medical condition, my goals in making medical decisions are as follows (insert your priorities, such as to receive comfort care, to not suffer with physical, mental, or emotional pain, to live as long as possible even if suffering pain, to keep mental function, to receive care at home, to let my agent decide what is best for me, to let my agent make the decision they think I would want, to live long enough to give my loved ones a chance to say goodbye if they choose to, your religious preferences, etc.):

_____

_____

_____

Cont...

ADVANCE HEALTHCARE DIRECTIVE

SECTION 2 — HEALTHCARE AGENT POWERS *(Continued)*

1. SEVERE BRAIN DAMAGE OR BRAIN DISEASE OR PERMANENT UNCONSCIOUSNESS:

This document contains only limited options for severe brain damage, severe brain disease, or permanent unconsciousness. You may use a different form if you would like more options e.g. for mild or moderate dementia.

(You may cross out any options with which you do not agree)

IF

- I become severely brain damaged, or
- I am permanently unconscious (e.g. in an irreversible coma or a persistent vegetative state), or
- I have severe dementia or other severe brain disease (e.g. severe Alzheimer's Disease) which has made me unable to recognize or interact with other people

AND my doctors believe there is no realistic hope of significant recovery,

I request that my agent respond to any **incurable** (and/or) **curable** (e.g. pneumonia) life-threatening conditions as follows:

Initials: _____ Keep me comfortable and allow death to occur

Initials: _____ Use all medical treatment that is needed to keep me alive

Goals: If I should suffer from permanent unconsciousness or severe and irreversible brain damage or brain disease which has made me unable to recognize or interact with other people, and from which my doctors believe there is no realistic hope of significant recovery of brain function, my goals in making medical decisions are as follows: (insert your personal priorities such as: aggressively treat me if I get sick, avoid aggressive treatments, keep me alive as long as possible, I want to receive comfort care, I want to receive treatment for physical, mental and emotional pain, etc.):

_____

_____

2. HEALTHCARE AGENT'S USE OF INSTRUCTIONS (Initial one option only).

Initials: _____ My Healthcare Agent must follow these instructions.

OR

Initials: _____ These instructions are only guidance. My Healthcare Agent shall have the final say and may override any of my instructions. (Indicate below any desired limitation of agent's authority.)

_____

_____

Signature: _____ Date:_____

Your signature and two witness signatures are also required at the end of this document – See Section 5.

ADVANCE HEALTHCARE DIRECTIVE

SECTION 3 – LIVING WILL

HEALTHCARE TREATMENT INSTRUCTIONS IN THE EVENT OF END-STAGE MEDICAL CONDITION

The following healthcare treatment instructions exercise my right to make my own healthcare decisions. These instructions are intended to provide clear and convincing evidence of my wishes to be followed when I cannot understand, make or communicate my treatment decisions.

1. If I have an end-stage medical condition which will result in my death, despite the introduction or continuation of medical treatment and there is no realistic hope of significant recovery, then I choose the following (indicate your choice by initialing your preference):

Initials: _____ **I do NOT want aggressive medical care,** and give the following instructions (cross out any treatment instructions with which you do not agree):

i. I direct that I be given healthcare treatment to relieve pain or provide comfort even if such treatment might shorten my life, suppress my appetite or my breathing, or be addictive. Medical or surgical treatment to relieve pain or provide comfort may be given even though I do not want it as a life prolonging procedure.

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

OR

Initials: _____ **I DO want aggressive medical care,** and give the following instructions:
I wish to receive all medical and surgical treatment needed to keep me alive as long as possible, even though my doctor believes that it will only delay the time of my death or maintain me in a state of permanent unconsciousness, and even though the treatment may cause me pain. In addition, I direct that I be given healthcare treatment to relieve pain or provide comfort provided that it does not hasten my death.

2. Tube Feeding: Artificial nutrition (food) or hydration (water) medically supplied by a tube through the nose, stomach, intestine, arteries, or veins.

If I am unable to eat or drink on my own and **I have an end-stage medical condition or I am permanently unconscious** and there is no realistic hope of significant recovery **(Initial one option only):**

Initials: _____ **I DO** want tube feedings (nutrition and hydration) to be given.

OR

Initials: _____ **I DO** want hydration *only* to be given.

OR

Initials: _____ **I do NOT** want tube feedings (nutrition or hydration) to be given.

Cont...

ADVANCE HEALTHCARE DIRECTIVE

SECTION 3 – LIVING WILL *(Continued)*

3. Guidance for Healthcare Agent:

Goals: If I have an end-stage medical condition or other extreme irreversible medical condition and there is no realistic hope of significant recovery, my specific goals in making medical decisions are as follows: (insert your personal priorities, such as comfort care, preservation of mental function, care at home, whether you want or do not want specific life prolonging procedures such as heart-lung resuscitation (CPR), mechanical ventilation (breathing machine), dialysis (kidney machine), surgery, chemotherapy, radiation treatment or antibiotics, your religious preferences, etc.):

_____

_____

_____

4. Healthcare Agent's Use of Instructions (Initial one option only).

Initials: _____ My Healthcare Agent **must follow** these instructions.

OR

Initials: _____ These instructions are **only guidance.** My Healthcare Agent shall have final say and may override any of my instructions. (Indicate any desired limitation of agent's authority.)

_____

_____

_____

Your signature and two witness signatures are also required at the end of this document – See Section 5.

ADVANCE HEALTHCARE DIRECTIVE

SECTION 4 – ORGAN DONATIONS AND ANATOMICAL GIFTS

1. Organ Donations: (initial one option only):

When I die, donate

● Initials: _____ ANY/ALL of my organs

● Initials: _____ ONLY the following organs (e.g. kidneys, liver, pancreas, skin, etc.)

Organs: _____

Please insert any limitations you desire on donation of organs (e.g. medical research, transplant only):

Limitations: _____

I understand that the hospital may provide artificial support, which may include a ventilator, after I am declared legally dead in order to make the above donations.

● Initials: _____ I do NOT want to donate my organs.

Signature: _____ Date:_____

2. Gift of Hands, Facial Tissue, Limbs, and Other Vascularized Composite Allografts:

Initials: _____ I DO consent to making a gift of my hands, facial tissue, limbs or other vascularized composite allografts and revoke any prior decision I have made to donate such body parts.

I also understand that:

- I have the option of requesting reconstruction of my body in preparation for burial
- In the case of donation of hands, facial tissue or limbs, it is possible my identity will not be protected
- Burial arrangements may be affected, and an open casket may not be possible.
- The hospital may provide artificial support, which may include a ventilator, after I am declared dead in order to make the donation.

Please insert any limitations you desire on donation of hands, facial tissue, limbs or other vascularized composite allografts:

_____

I would like reconstructive surgery BEFORE burial (initial one option only): _____ Yes _____ No

OR

Initials: _____ I do NOT consent to making a gift of my hands, facial tissue, limbs or other vascularized composite allografts.

Signature: _____ Date:_____

Your signature and two witness signatures are also required at the end of this document – See Section 5.

ADVANCE HEALTHCARE DIRECTIVE

SECTION 5 — WITNESSES

Legal Protection

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

Having carefully read this document, I have signed it **this** _____ **day of** _____, **20** _____, revoking all previous healthcare powers of attorney and healthcare treatment instructions.

Signature:_____

Name:_____

Address:_____

Date of Birth:_____

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 in your place and on your behalf may not be a witness. (It is preferable if the witnesses are not your heirs, nor your creditors, nor employed by any of your healthcare providers.)

Witness 1 Signature: _____

Print Name: _____

Date: _____

Address: _____

_____

Witness 2 Signature: _____

Print Name: _____

Date: _____

Address: _____

_____

NOTARIZATION (OPTIONAL)

(Notarization of document is not required by Pennsylvania law, but if the document is both witnessed and notarized, it is more likely to be honored by the laws of some other States.)

On **this** _____ **day of** _____, **20** _____, before me personally appeared the aforesaid principal, to me known to be the person described in and who executed the foregoing instrument and acknowledged that he/she executed the same as his/her free act and deed.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal in the County of

_____, State of _____ the day and year first above written.

_____
My commission expires

_____
Notary Public

ADVANCE HEALTHCARE DIRECTIVE NOTIFICATION

My Name: _____

I have a Healthcare Power of Attorney and a Living Will, and I have talked with my family and my doctor about the care I want. If I am unable to speak for myself, please contact:

Name of Agent:	Name of Alternate Agent:
_____	_____
Best Telephone No.:	Best Telephone No.:
_____	_____

Fill out this card, cut it out along the border line, and keep it in your wallet with your medical insurance card and driver's license.