

ADVANCE HEALTH CARE DIRECTIVE

MY NAME IS _____.

**PART 1: HEALTH CARE POWER OF ATTORNEY
DESIGNATION OF AGENT:**

I designate the following individual as my agent to make health care decisions for me:

(Name and relationship of individual designated as health care agent)

(Address) (City) (State) (Zip code) (Home phone) (Work phone) (E-Mail)

If I revoke my agent’s authority or if my agent is not willing, able, or reasonably available to make decisions for me, I designate the following individual as my alternate agent:

(Name and relationship of individual designated as alternate health care agent)

(Address) (City) (State) (Zip code) (Home phone) (Work phone) (E-Mail)

WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE:

My agent’s authority becomes effective when my primary physician determines that I am unable to make my own health care decisions unless I mark the following box.

___ If I mark this box, my agent’s authority to make health care decisions for me takes effect immediately. However, I always retain the right to make my own decisions about my health care and to revoke this authority as long as I am mentally capacitated.

AGENT'S AUTHORITY AND OBLIGATION:

I intend my agent’s authority to be as broad as possible subject only to any instructions and limitations I may state in Part 2 of this form or as I may otherwise provide orally or in writing. To the extent my wishes are unknown, my agent shall make health care 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. If a guardian of my person needs to be appointed for me by a court, I nominate my agent.

PART 2: INDIVIDUAL INSTRUCTIONS FOR HEALTH CARE

A. END-OF-LIFE DECISIONS:

I wish to provide instructions regarding end-of-life decisions based on different possible situations I may face in the future.

(Strike through any of the following provisions you do not want)

- If I am close to death and life support would only postpone the moment of my death, **OR**
- If I am in an unconscious state such as an irreversible coma or a persistent vegetative state and it is unlikely that I will ever become conscious again, **OR**
- If I have brain damage or a brain disease that makes me permanently unable to interact and to make and communicate health care decisions about myself and the likely risks and burdens of treatment would outweigh the expected benefits:

THEN

(Check only one of the three following boxes. You may also initial your selection)

___ (a) Choice Not To Prolong Life--I do not want my life to be prolonged.

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. **OR**

___ (c) Choice To Be Made By Health Care Agent--I want my agent who is designated in Part 1 of this document or in a separate document to make end-of-life decisions for me.

B. ARTIFICIAL NUTRITION AND HYDRATION -- FOOD AND FLUIDS:

Artificial nutrition and hydration must be provided, withheld or withdrawn in accordance with the choice I have made in the preceding paragraph A unless I mark the following box.

___ If I mark this box, artificial nutrition and hydration must be provided regardless of my condition and regardless of the choice I have made in paragraph A.

C. RELIEF FROM PAIN:

___ If I mark this box, I direct that treatment to alleviate pain or discomfort should be provided to me even if it hastens my death.

D. OTHER MATTERS:

A copy of this form has the same effect as the original.

My agent shall not be obligated to assume any personal financial responsibility when making decisions in accordance with this document. My agent has the authority to request, receive, examine, copy and consent to the disclosure of medical or any other healthcare information, including medical files and records. This includes my delegated authority for my agent to act as my personal representative for release of all individually identifiable health information concerning me by both covered and non-covered entities under the provisions of the Health Insurance Portability and Accountability Act (HIPAA) and/or other Federal and State laws pertaining to healthcare and healthcare information.

X _____
(My Signature)

(Date)

(My Printed Name)

(My Address)

WITNESSES:

This document must either be signed by two qualified adult witnesses who witness or acknowledge the signature; or be acknowledged before a notary public in the state.

ALTERNATIVE NO. 1

First Witness*

*I am not the person appointed as agent by this document, and that I am not a health care provider, nor an employee of a health care provider or facility. I am not related to the principal by blood, marriage, or adoption, and to the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

(Signature of Witness)

(Date)

(My Printed Name)

(Address of Witness)

Second Witness**

**I am not the person appointed as agent by this document, and I am not a health care provider, nor an employee of a health care provider or facility.

(Signature of Witness)

(Date)

(Printed Name of Witness)

(Address of Witness)

ALTERNATIVE NO. 2

State of Hawai'i)
City and County of Honolulu)

On this _____ day of _____, in the year _____, before me,

(Insert name of notary public) appeared
_____, personally known to me (or proved to me on the
basis of satisfactory evidence) to be the person whose name is subscribed to this
instrument, and acknowledged that he or she executed it.

Notary Seal
