LONG FORM
ADVANCE HEALTH CARE DIRECTIVE

MY NAME IS _____

MY ADDRESS IS:

_____

(Address)

_____

(City) (State) (Zip code)

PART 1
DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

(1) DESIGNATION OF AGENT: I designate the following individual as my agent to make health care decisions for me:

_____

(Name of individual you choose as agent)

_____

(Address)

_____

(City) (State) (Zip code)

_____ _____ _____

(Home phone) *(Work phone)* *(E-mail)*

OPTIONAL: If I revoke the authority of my agent and first alternate agent or if neither is willing, able, or reasonably available to make a health care decision for me, I designate as my second alternate agent:

_____

(Name of individual you choose as agent)

_____

(Address)

_____

(City) (State) (Zip code)

_____ _____ _____

(Home phone) *(Work phone)* *(E-mail)*

(2) AGENT'S AUTHORITY: **(Strike through any of the following provisions you do not want. You can add provisions on the form or attach additional pages.)**

My agent is authorized to make all of the following health care decisions for me:

- To provide consent (or refuse consent) to and to enter into contracts on my behalf for any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition, including admission to or discharge from a health care facility or program, give approval or disapproval to diagnostic tests, medical or surgical procedures, programs of medication, the use of alternative or complementary therapies as well as decisions to participate in education, research and experimental programs.
- To make decisions regarding orders not to resuscitate or to attempt resuscitation (DNR or DNAR), including out-of-hospital "Comfort Care Only–Do-Not-Resuscitate" (CCO-DNR) documents, as well as Provider Orders for Life Sustaining Treatment (POLST) forms for immediately actionable decisions to provide, withhold, or withdraw nutrition and hydration and all other forms of health care to keep me alive.
- To request, receive, examine, copy, and consent to the disclosure of medical or any other health care information, including medical files and records. I also grant my agent the power to authorize, or to revoke any authorization for, the release, disclosure and use of any of my health and medical information, including, but not limited to, my entire medical record, my medical bills, all information in my medical records relating to AIDS (Acquired Immune Deficiency Syndrome) or HIV, alcohol and/or drug abuse treatment, or behavioral or mental health services, and any written opinion relating to my capacity, my competency, or my ability to manage my own affairs or to make my own decisions, and such power shall apply to any information governed by the Health Insurance Portability and Accountability Act of 1996 (also known as HIPAA), 42 USC 1320d and 45 CFR 160-164, and any other applicable federal, state or local statute or regulation. In addition, my agent shall have the power to pay any fee charged for duplication of records, and to release health care providers and other entities from all liability and claims whatsoever pertaining to the disclosure of information as contained in the records released pursuant to such authorization.
- To communicate with, select, and discharge health care providers, organizations, institutions and programs, including hospice programs and to make and change health care choices and options relating to plans, services, and benefits.
- To apply for public or private health care programs and benefits, to include Medicare, Medicaid, Med-Quest or other federal, state, local or private programs without my agent incurring any personal financial liability.
- To make all other health care decisions for me, except as I state here:

(Consult with a mental health professional and/or attorney for appropriate language if you wish to give your agent additional information or instructions about decisions regarding mental illness. You may make a separate mental illness advance directive or include such provisions in this advance directive. Use additional sheets if needed.)

(3) 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.

(4) AGENT'S OBLIGATION: My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. 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. My agent shall not be obligated to assume any personal financial responsibility when making decisions in accordance with this document.

(5) NOMINATION OF GUARDIAN: If a guardian of my person needs to be appointed for me by a court, I nominate my agent. If another person is appointed as guardian and my agent is willing and able to act, I would prefer my agent to have precedence in making health care decisions for me.

PART 2
INSTRUCTIONS FOR HEALTH CARE

If you are satisfied with allowing your agent to determine what is best for you in making end-of-life decisions, you need not fill out this part of the form. **If you do fill out this part of the form, you may strike through any wording you do not want.**

(6) END-OF-LIFE DECISIONS: I direct that my health care providers and others involved in my care to provide, withhold, or withdraw treatment in accordance with the choice I have marked below: (Check any one of the two following boxes. You may cross out any unwanted provisions.)

____☐ Choice Not To Prolong Life
I do not want my life to be prolonged if

(i) I have an incurable and irreversible condition that will result in my death within a relatively short time, or
(ii) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or
(iii) The likely risks and burdens of treatment would outweigh the expected benefits, OR

____☐ 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

____☐ 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.

(7) ARTIFICIAL NUTRITION AND HYDRATION: Artificial nutrition and hydration must be provided, withheld or withdrawn in accordance with the choice I have made in paragraph (6) 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 (6)

(8) RELIEF FROM PAIN: If I mark the following box,

_____ ☐ I direct that treatment to alleviate pain or discomfort should be provided to me even if it hastens my death.

(9) OTHER WISHES: (If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here:)

PART 3
DONATION OF ORGANS/BODY AT DEATH (OPTIONAL)

(10) Upon my death: (Mark applicable box(es):

_____ ☐ (a) I give any needed organs, tissues, or parts, OR

_____ ☐ (b) I give the following organs, tissues, or parts only

_____ ☐ (c) My gift is for the following purposes:
(Strike through any of the following you do not want)
- Transplant
- Therapy
- Research
- Education

_____ ☐ (d) I give my body to the University of Hawai'i John A. Burns School of Medicine for its research and education purposes. (Obtain information/forms from the Medical School's Department of Anatomy.)

PART 4
PRIMARY PHYSICIAN/HEALTH CARE/HOSPICE FACILITY (OPTIONAL)

(11) I designate the following physician as my primary physician:

_____

(Name of physician)

_____

(Address)

_____

(City) (State) (Zip code)

_____

(Phone)

OPTIONAL: If the physician I have designated above is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician:

_____

(Name of physician)

_____

(Address)

_____

(City) (State) (Zip code)

_____

(Phone)

(12) I have the following preference of hospitals and/or nursing homes/hospice facilities if I require such care:

_____

(You may name a facility, or you may indicate a preference for hospice care administered at home or in a hospice facility, a preference not to be institutionalized, a preference to remain at home, etc.)

PART 5
RELIGIOUS OR SPIRITUAL INFORMATION (OPTIONAL)

(13) I identify with the following church, temple, or other spiritual group:

_____

(14) I would like to receive my spiritual care from:

_____

(Name of individual or group)

_____

(Address)

_____

(City) (State) (Zip code)

_____

(Phone)

PART 6
ADDITIONAL INSTRUCTIONS OR INFORMATION (OPTIONAL)
WHAT IS IMPORTANT TO ME

(15) You may include information about yourself, what is important to you, your ethical, spiritual and religious instructions, requests for prayer and forgiveness, what makes your life worth living, and the things you value, etc. You may also include additional information about when you would not want your life prolonged by medical treatment (examples: if not able to communicate, if not able to enjoy eating), where you want to spend your last days, etc.:

____ ☐ If I mark this box, I have attached additional instructions or information. (Sign and date each added page and attach to this form.)

(16) EFFECT OF COPY: A copy of this form has the same effect as the original.

SIGNATURE: Sign and date the form here:

_____ _____

(Sign Your Name) *(Date)*

_____

(Print Your Name)

WITNESSES: The power of attorney portion of this document will not be valid for making health care decisions unless it is either (a) signed by two qualified adult witnesses who are personally known to you and who are present when you sign or acknowledge your signature; or (b) acknowledged before a notary public in the state.

ALTERNATIVE NO. 1 (WITNESSES)

FIRST WITNESS

I declare under penalty of false swearing pursuant to section 710-1062, Hawai`i Revised Statutes, that the principal is personally known to me, that the principal signed or acknowledged this power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, that 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)*

_____

(Printed Name of Witness)

_____

(Address of Witness)

SECOND WITNESS

I declare under penalty of false swearing pursuant to section 710-1062, Hawai`i Revised Statutes, that the principal is personally known to me, that the principal signed or acknowledged this power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, that 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.

_____ _____

(Signature of Witness) *(Date)*

_____

(Printed Name of Witness)

_____

(Address of Witness)

ALTERNATIVE NO. 2 (NOTARY PUBLIC)

State of Hawai'i _____)
) SS
County of _____)

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

_____

(Signature of Notary Public)

My Commission Expires: _____

Document Date _____ # Pages: _____

Name: _____, _____ Circuit

Doc. Description: _____

_____

Signature _____ Date _____

Notary Certification