SHORT FORM
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.

NOMINATION OF A GUARDIAN:

If a guardian 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 guardian, I nominate the alternate agents who I have named, in the order designated.

PART 2: INSTRUCTIONS FOR HEALTH CARE

(If you are satisfied to allow 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 add wording you may prefer and you may strike any wording you do not want.)

A. 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 following choice I have marked below: Check only one box.

_____ ☐ (a) Choice ***Not*** To Prolong Life
I do not want my life to be prolonged if (i) I have an incurable and irresversible condition that will result in my death within a relatively short time, (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 outweight the expected benefits, 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.

(If you wish to add to the instructions or to write our own, you may do so in section D below.)

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. ADDITIONAL INSTRUCTIONS OR INFORMATION:

(Optional—what is important to you, what makes your life worth living, the things you value, your thoughts on life-prolonging treatment, preferences for physician/health care facility; hospice, directions for organ/body donation, religion or spiritual information, etc.)

_____

_____

_____

_____

_____

_____ ☐ If I mark this box, I have attached additional instructions or information that I wish to incorporate into this advance directive. (Sign and date each added page and attach to this form.)

OTHER MATTERS:

A copy of this document has the same effect as the original. (Strike through any provisions with which you do not agree). My agent has the following powers with respect to my health care:

a. To talk with health care providers and insurers and to arrange for and authorize my treatment, admission to or discharge from any hospital, nursing home, residential care, assisted-living, home health, hospice or similar facility or service and to apply for and change any health care-related service, facility or insurance for me, and to apply for public or private health care benefits.

b. To request, receive, examine, copy and consent to the disclosure of medical or any other health care information, including medical files and records under the Health Insurance Portability and Accountability Act (HIPAA) and/or other federal and state laws pertaining to health care and health care information.

c. To make decisions regarding Provider Orders for Life Sustaining Treatment (POLST) forms.

d. To sign necessary documents on my behalf related to the above matters without my agent assuming personal financial responsibility.

_____ _____

(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 (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

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