HEALTH CARE DIRECTIVE

I, _________, understand this document allows me to do the following:

PART I: Name another person (called the health care "agent") to make health care decisions for me if I am unable to decide or speak for myself. My agent must make health care decisions for me based on the instructions I provide in this document (Part II), the wishes I have made known to him or her, or must act in my best interest if I have not made my health care wishes known.

AND/OR

PART II: Give health care instructions to guide others making health care decisions for me. If I have named a health care agent, these instructions are to be used by the agent. These instructions may also be used by my health care providers, my family, and others assisting with my health care in the event I cannot make decisions for myself.

PART I: APPOINTMENT OF HEALTH CARE AGENT

This is who I want to make health care decisions for me if I am unable to decide or speak for myself.

Whenever I am unable to make health care choices or speak for myself, I trust and appoint ________________________, my ______________________, as my agent to make health care decisions for me. His/her address is ________________________________ and telephone number is ____________________. If _________________________ is not reasonably available or is unwilling to act, I trust and appoint ______________________, my ________________, to be my successor agent. His/her address is ________________________, and telephone number is _______________. If ______________________ is not reasonably available or is unwilling to act, I trust and appoint ____________________, my ____________, to be my successor agent. His/her address is ___________________________, and telephone number is ___________________.

Designation of Personal Representative. I designate the individuals appointed as my health care agents and alternate agents as my personal representatives for purposes of the Health Insurance Portability and Accountability Act of 1996. My personal representatives may act on my behalf in receiving and authorizing the use and disclosure of protected health information. I waive all medical privilege in favor of any agent and personal representative I appoint under this Health Care Directive. My agent may assert on my behalf the right to receive, review, and obtain copies of my medical records and to consent to disclosure of those records.

My agent is automatically given the powers listed below in (A) through (D). My agent must follow my instructions in this document or any other instructions I have given to my agent. If I have not given health care instructions, then my agent must act in my best interest.

My agent has the power to:

(A) Make any health care decision for me. This includes the power to give, refuse, or withdraw consent to any care, treatment, service, or procedures. This includes deciding whether to stop or not start health care that is keeping me or might keep me alive, and deciding about intrusive mental health treatment.

(B) Choose my health care providers.

(C) Choose where I live and receive care and support when those choices relate to my health care needs.

(D) Review my medical records and have the same rights that I would have to give my medical records to other people.

If I DO NOT want my health care agent to have a power listed above in (A) through (D), or if I want to LIMIT any power (A) through (D), I MUST say that here: ________________________________
____

My health care agent is NOT automatically given the powers listed below in (1) and (2). If I WANT my agent to have any of the powers in (1) and (2), I must INITIAL the line in front of the power, and then my agent WILL HAVE that power.

________ (1) To decide whether to donate my organs when I die.
________ (2) To decide what will happen to my body when I die (burial, cremation).

Additional comments about my agent's powers or limits on the powers: ______________________
____

PART II: HEALTH CARE INSTRUCTIONS

These are instructions for my health care when I am unable to decide or speak for myself. These instructions must be followed (so long as they address my needs).

NOTE: Complete Part II only if you wish to give health care instructions. If you appointed an agent in Part I, completing Part II is optional but would be very helpful to your agent. However, if you chose not to appoint an agent in Part I, you MUST complete some or all of Part II to have a valid health care directive.

These Are My Beliefs And Values About My Health Care:

My goals for my health care are: ____
____

My fears about my health care:____

____

My beliefs about when life would be no longer worth living: ____

____

My spiritual or religious beliefs and traditions: ____

____

My thoughts about how my medical condition might affect my family: ____

____

This Is What I Want And Do Not Want For My Health Care:
(Discuss general feelings and/or specific treatments, or leave blank)

If I had a reasonable chance of recovery and were *temporarily* unable to decide or speak for myself:

____

____

If I were dying and unable to decide or speak for myself, I would want:____

____

- ☐ I want to have life support treatment if my doctor believes it could help, but I want my doctor to stop giving me life-support treatment if it is not helping my health condition or symptoms

OR

- ☐ I do not want life support treatment.

Life support means any medical procedure, device or medication to keep me alive, such as cardiopulmonary resuscitation in the event my heart stops, mechanical ventilation if I am not able to maintain my respiratory status, aggressive medication support, such as intravenous antibiotics or chemotherapy, food and fluids by means of gastrostomy or nasal gastric tube feeding when I am no longer able to swallow, or sustenance by means of an IV solution if I cannot swallow on my own.

If I were permanently unconscious and unable to decide or speak for myself, I would want: ______

____

If I were not in a terminal condition but nevertheless completely dependent on others for my care and were unable to decide or speak for myself: ____

____

In all circumstances, my doctors should try to keep me comfortable and reduce my pain. This is how I feel about pain relief if it would affect my alertness or if it could shorten my life:_____________

____

Other Things I Want Or Do Not Want For My Health Care

Who I would like to be my doctor: ____
____

Where I would like to live to receive health care: ______________________________
____

Where I would like to die and other wishes I have about dying: __________________
____

My wishes about donating parts of my body when I die (*place an "X" next to the section below that expresses your wishes*):

__________ In the event of my death, I would like to donate my organs. I understand that to become an organ donor, I must be declared brain dead. I agree that my organ function may be maintained artificially on a breathing machine, (i.e. artificial ventilation), so that my organs can be removed.

- Limitations (if any) on donation of my organs: _______________
  ____
- I have/have not (circle option) agreed in another document or on another form to donate some or all of my organs when I die: _____
  (List type of document, i.e., driver's license)

__________ I do not wish to become an organ donor upon my death.

My wishes about what happens to my body when I die (cremation, burial): ___________
____

Any other things: ____
____

I am thinking clearly, I agree with everything that is written in this document, and I have made this document willingly.

Date: ________________________ ______________________________
Date of birth: __________________ NAME
Address: ______________________
____

If I cannot sign my name, I can ask someone to sign this document for me:

______________________ Signature of the person I asked to sign this document for me.

______________________ Printed name of the person I asked to sign this document for me.

STATE OF MINNESOTA)
)
COUNTY OF __________)

In my presence on ___________, 2012, ____________________ acknowledged his/her signature on this document or acknowledged that he/she authorized the person signing this document to sign on his/her behalf. I am not named as an agent or alternate agent in this document.

____
Notary Public

OR

(Sign and date here in the presence of two adult witnesses, neither of whom is entitled to any part of your estate under a Will or by operation of law, and neither of whom is your proxy.)

I certify that the maker voluntarily signed this declaration in my presence and that the maker is personally known to me. I am not named as a proxy by the declaration, and to the best of my knowledge, I am not entitled to any part of the estate of the declarant under a Will or by operation of law.

WITNESS_______________________ADDRESS____________________________

WITNESS_______________________ADDRESS____________________________

REMINDER: **Keep the signed original with your personal papers. Give signed copies to your doctors, family and proxy.**