

**DRAFT COPY OF**

**HEALTH CARE DIRECTIVE**

**OF**

\_\_\_\_\_

1. Purpose of the Form. I, \_\_\_\_\_, also known as \_\_\_\_\_, and formerly known as \_\_\_\_\_, of \_\_\_\_\_, [address], state that I wish and expect to be fully informed about and allowed to participate in any and all decision-making processes regarding my health care, including those about procedures that may be used to prolong or sustain my life, for as long as, and to the extent that I am able. This document is executed so that if I lack decision-making capacity to make a health care decision, my health care agent(s) may make decisions concerning my health care, including the withholding or withdrawing of life-sustaining and life-prolonging procedures, in accordance with instructions herein, or if not covered by this document, with instructions which I have discussed with my agent or in my best interests if I have not made my health care wishes known.

2. Appointment of Health Care Agent(s). I appoint my \_\_\_\_\_ (*spouse, sibling, child, friend, etc.*), \_\_\_\_\_, as my agent to make any health care decisions for me when, in the judgment of my attending physician, I am unable to make or communicate the decision myself. If for any reason \_\_\_\_\_ is not reasonably available to serve, I appoint my \_\_\_\_\_ (*spouse, sibling, child, friend, etc.*), \_\_\_\_\_, as my alternative agent. If for any reason \_\_\_\_\_ is not reasonably available to serve, I appoint my \_\_\_\_\_ (*spouse, sibling, child, friend, etc.*), \_\_\_\_\_, as my alternative agent. Any reference herein to "my agent" shall also refer to any alternative agent.

3. Powers of Agent(s).

3.1 My agent has the power to make any health care decision for me. This power includes the power to give consent, to refuse consent, or withdraw consent to any care, treatment, service, or procedure to maintain, diagnose, or treat my physical or mental condition, including giving me food or water by artificial means. My agent has the power, where consistent with the laws of this state, to make a health care decision to withhold or stop health care necessary to keep me alive.

3.2 My agent must act consistently with my wishes as stated in this document.

3.3 My agent has the same right as I would have to receive, review, and obtain copies of my Medical records and to consent to disclosure of these records.

3.4 My agent has the power to choose where I live when I need health care and what personal security measures are needed to keep me safe.

4. Designation of Personal Representative For Purposes of HIPAA. 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 and any other applicable federal or state law or regulation. 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.

5. Terminal Condition Instructions. If in the opinion of my attending physician, confirmed by the opinion of at least one additional physician, I am in a terminal condition and cannot express my wishes, I wish to be allowed to die naturally and not be kept alive by artificial means or heroic measures. I do not want any medical treatment that will not substantially improve my condition or help me recover, but will only postpone the moment of my death. However, I want whatever care is appropriate to keep me as comfortable and as free of pain as is reasonably possible, including the administration of pain relieving drugs and surgical or medical procedures calculated to relieve my pain, [even though some drugs or procedures may hasten my death]. **NOTE: This paragraph may be amended to state your personal desires. For example, it may include a statement that you do or do not want artificially administered nutrition (tube feeding) or hydration if you are terminal. It might include special instructions if you are pregnant at the time of the terminal condition.**

6. Permanent Vegetative State Instructions. If in the opinion of my attending physician, confirmed by the opinion of at least one consulting expert physician, I am in a permanently unconscious or vegetative state, without reasonable medical likelihood of restoration, I desire:

**a) That I receive all appropriate and medically indicated life-supporting treatment or procedures, including artificial nutrition and hydration, along with medications that will bring me comfort and relief from my symptoms.**

or

**b) That my physicians start a trial of treatment and/or therapy to be given for a reasonable time to be determined by my agent and my physicians. This may include all treatments necessary to restore me to a reasonable quality of life, to help make me more comfortable or to otherwise benefit me. Should it be determined that such treatments are futile, I would then want such treatments and all artificial life supports discontinued, even if this will result in my death, however, I want whatever care is appropriate to keep me as comfortable and as free of pain as is reasonably possible.**

or

**c) That all artificial life support, including artificial nutrition and hydration, be discontinued, but that appropriate pain relief medications and procedures be provided.**

or

**d) Write out your wishes.**

7. Nomination of Guardian. If there is a petition for the appointment of a guardian to have authority with respect to decisions concerning life-sustaining procedures or other health care for me, I nominate, pursuant to Minnesota Statutes, the agent(s) designated in this Health Care Directive for appointment by the court as guardian. I ask that the guardian be given such authority to make health care decisions as may be permitted under Minnesota law.

8. Nomination of Conservator. If there is a petition for appointment of a conservator to manage my assets, I hereby nominate \_\_\_\_\_ as my conservator. If \_\_\_\_\_ is unable or unwilling to serve, then I nominate said \_\_\_\_\_ as my conservator.

9. Additional Instructions.

9.1 I request that my body be buried/cremated after my death.

9.2 In the event that there is a request for an autopsy for medical purposes, I direct that an autopsy be/not be permitted. **NOTE Or: I direct that the decision be made by my agent in his/her sole discretion.**

9.3 [ALT 1] I am not an organ donor. I desire that my organs or tissue not be permitted to be used for donation to another person, for medical research, or for any other purpose. [ALT 2] I am an organ donor. I desire that any of my organs or tissue which can be used to improve or extend the life of another person, [or which can be used for medical research,] be used for those purposes.

10. Revocation.

10.1 I have the right to revoke the appointment of the person(s) named above to act on my behalf at any time by communicating that decision to my agent or my health care provider.

10.2 If my agent is my spouse, the commencement of proceedings for dissolution, annulment, or termination of my marriage or actual dissolution, annulment, or termination of my marriage shall revoke the appointment of my spouse as my agent.

11. Agents. The names, addresses and telephone numbers of my agent and any alternative agents are listed herewith and are current as of the date of this instrument.

**Please provide the following information for each person you are naming as Health Care Agent or Alternate Health Care Agent.**

**AGENT:**

Agent's name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone: \_\_\_\_\_

Relationship: \_\_\_\_\_

**CO-AGENT:**

Agent's name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone: \_\_\_\_\_

Relationship: \_\_\_\_\_

**FIRST ALTERNATE AGENT:**

Agent's name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone: \_\_\_\_\_

Relationship: \_\_\_\_\_

**SECOND ALTERNATE AGENT:**

Agent's name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone: \_\_\_\_\_

Relationship: \_\_\_\_\_

*Although, this is **ONLY** the **draft** Health Care Directive, please sign and date this page so that our office can verify that these are your desires.*

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

DATED: \_\_\_\_\_

SIGNED: \_\_\_\_\_