Advance Health-Care Directive Form

18-A M.R.S.A. §§ 5-801 - 5-817

(See Instructions)

PART 1—Selection of My Agent

(Durable Power of Attorney for Health Care)

(Sections 1 through 4)

(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)

OPTIONAL: If I revoke my Agent's authority or if my Agent is not willing, able or reasonably available to make a health-care decision for me, I designate as my first alternate Agent:

_____

(name of individual you choose as first alternate Agent)

_____

(address)

_____

(city) (state) (zip code)

_____

(home phone)

_____

(work phone)

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 second alternate Agent)

_____

(address)

_____

(city) (state) (zip code)

_____

(home phone)

_____

(work phone)

(2) AGENT'S AUTHORITY:

My Agent is authorized to make all health-care decisions for me, including decisions to provide, withhold or withdraw artificial nutrition and hydration and all other forms of health care to keep me alive, except as I state here or in Part 2 of this form:

_____

_____

_____

_____

(Add additional pages if needed.)

Authority under HIPAA: I intend for my Agent herein appointed to be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records. I grant to my Agent the power and authority to serve as my Personal Representative for all purposes under the Health Insurance Portability and Accountability Act of 1996 and its regulations ("HIPAA"), 42 USC 1320d and 45 CFR 160-164.

(3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: [check one box]

[ ] My Agent's authority becomes effective when my primary physician determines that I am unable to make my own health-care decisions.

OR

[ ] My Agent's authority to make health-care decisions for me takes effect immediately and continues after I am no longer able to make decisions for myself.

(4) AGENT'S OBLIGATION: My Agent shall make health-care decisions for me in accordance with this power of attorney for health care, any specific 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.

You have the right to revoke Part 1 of this form at any time. You must do so in writing or by personally notifying your primary physician.

18-A M.R.S.A. § 5-803

PART 2—Instructions for My Health Care

(Sections 5 through 8)

You need not fill out this part of the form if you are satisfied to allow your Agent to determine what is best for you in making end-of-life and other health care decisions. However, if you prefer, you can give your power of attorney specific instructions.

If you choose to fill out this part of the form, you may cross out any wording you do not want or add additional instructions at the end of any section or in section 8. ..If you cross out any wording, place your initials next to the part that you cross out.

(5) 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 choices I have noted below:

[ ] Choice Not To Prolong Life

I do not want my life to be prolonged if: **[check all boxes that apply]**

[ ] I have an incurable and irreversible condition that will result in my death within a relatively short time,

[ ] I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness,

[ ] the likely risks and burdens of treatment would outweigh the expected benefits,

[ ] other _____

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.

Other instructions: _____

_____

(6) ARTIFICIAL NUTRITION AND HYDRATION: [check one box]

[ ] Artificial nutrition and hydration must be provided, withheld or withdrawn in accordance with the choice(s) I have made in paragraph (5);

OR

[ ] Artificial nutrition and hydration must be provided regardless of my condition and regardless of the choice(s) I have made in paragraph (5).

Other instructions: _____

_____

_____

(7) RELIEF FROM PAIN: I direct that treatment for alleviation of pain or discomfort **[check one box]**

[ ] be provided at all times, even if it hastens my death:

OR

[ ] Other [state instructions]: _____

_____

(8) OTHER INSTRUCTIONS: 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.

_____

_____

_____

_____

_____

_____

(Add additional pages if needed)

You may revoke all or portions of Parts 2 to 5 of the advanced health care directive at any time and in any manner that communicates an intent to revoke.

18-A M.R.S.A. § 5-803

PART 3—Donation of My Organs

(Sections 9 and 10)

(9) Upon my death [check one box]

[ ] I do not wish to donate any organs.

[ ] I give any needed organs, tissues or parts.

OR

[ ] I give only the following organs, tissues or parts:

_____

_____

(10) If I have decided to donate organs, my gift is for the following purposes:
[check all boxes that apply]

[ ] Transplant

[ ] Therapy

[ ] Research

[ ] Education

[ ] Any of the above

[ ] Other _____

PART 4—Choice of Primary Physician

(Section 11)

(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)

PART 5—Nomination of Guardian

(Section 12)

(12) If a probate court judge finds that a guardian must be appointed to make decisions for me:
[check one box]

[ ] I nominate the Agent designated in Part 1 of this form to be my guardian. If that Agent is not willing, able or reasonably available to act as guardian, I nominate the alternate Agents whom I have named, in the order designated.

OR

[ ] I nominate the following person to serve as my guardian**:**

_____

(name of proposed guardian)

_____

(address)

_____

(city) (state) (zip code)

_____

(home phone)

_____

(work phone)

PART 6—Signatures

YOUR SIGNATURE: (Required)

_____

(sign your name)

_____

(print your name)

_____

(address)

_____

(city) (state) (zip code)

_____

(date)

SIGNATURES OF TWO WITNESSES: (Required)

First witness	**Second witness**
_____	_____
(signature of witness)	(signature of witness)
_____	_____
(print name)	(print name)
_____	_____
(address)	(address)
_____	_____
(city) (state) (zip code)	(city) (state) (zip code)
_____	_____
(date)	(date)

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

18-A M.R.S.A. § 5-812

Notary Acknowledgement (Optional)

Personally appeared before me the above-named _____ who took an oath and acknowledged this Advance Health Care Directive, including durable power of attorney for healthcare, as his/her free act and deed.

Date:_____ _____

Notary Public State of:_____

Commission Exp.:_____ _____

Print name