Prepared by:

Grantor: **Name: _____**

Agents: **Name: _____**
Address: _____
_____
Phone: _____

Alternate Agent: **Name: _____**
Address: _____
_____
Phone: _____

ADVANCED HEALTH-CARE DIRECTIVE

You have the right to give instructions about your own health care. You also have the right to name someone else to make health-care decisions for you. This document lets you do either or both of these things. It also lets you express your wishes regarding the designation of your primary physician.

PART 1 of this document is a power of attorney for health care and lets you name another individual as agent to make health-care decisions for you if you become incapable of making your own decisions or if you want someone else to make those decisions for you now even though you are still capable. You may name an alternate agent to act for you if your first choice is not willing, able, or reasonably available to make decisions for you. Unless related to you, your agent may not be an owner, operator, or employee of a residential long-term health-care institution at which you are receiving care.

Unless you limit the authority of your agent herein, your agent **may make all health care decisions for you**. This document has a place for you to limit the authority of your agent. You need not limit the authority of your agent if you wish to rely on your agent for all health-care decisions that may have to be made.

PART 2 of this document lets you give specific instructions about any aspect of your health care. Choices are provided to you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive, including the provision of artificial nutrition and hydration, as well as the provision of pain relief.

PART 3 of this document lets you donate organs at death if you want to.

PART 4 lets you designate a physician to have primary responsibility for your health care and contains miscellaneous provisions and space to add any other wishes you may have.

I, _____, Social Security No. _____, do hereby designate and appoint _____, as my attorney(s)-in-fact (hereinafter referred to as "Agent(s)") to make health care decisions authorized in this document. If _____ is not available or become ineligible to act as my Agents to make a health care decision for me or loses the mental capacity to make health care decisions for me, or if I revoked that person's appointment or authority to act as my Agent to make health care decisions for me, then I designate and appoint _____ to serve as my Agent(s) to make health care decisions for me as authorized in this document.

For the purposes of this document, "health care decision" means consent, refusal of consent, or withdrawal of consent in any care, treatment, service or procedure to maintain, diagnose, or treat my physical or mental condition.

1. General Statement of Authority Granted. Subject to any limitation in this document, I hereby grant to my Agent full authority to make health care decisions for me to the same extent that I could make such decisions for myself if I had the capacity to do so, including decisions to provide, withhold, or withdraw artificial nutrition and hydration, and all other forms of health care to keep me alive except as stated here:

   _____

2. Agent's Obligation. In making decisions, my Agent shall attempt to discuss the proposed decision with me to determine my desires if I am able to communicate in any way. If my Agent cannot determine the choice I would want made, my Agent shall make health care decisions that are consistent with my desires as stated in this document or otherwise made known to my Agent, including, but not limited to my desires concerning obtaining or refusing or withdrawing life-prolonging care, treatment, services, and procedures.

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.

☐ If I mark this box my Agent's authority under section 9.4 of this Advanced Health Care Directive takes effect immediately to the extent necessary for my primary physician to receive and distribute information necessary to determine whether or not I am able to make my own health care decisions.

PART 2

4. End of Life Decisions. I direct that my health-care provider and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below:

☐ (a) 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, (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

☐ (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.

5. Artificial Nutrition and Hydration: Artificial nutrition and hydration must be provided, withheld, or withdrawn in accordance with the choice I have made in paragraph 4 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 4.

6. Relief from Pain.

☐ If I mark this box, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if such pain relief treatment hastens my death.

7. Power to Maintain Me in My Residence. My Agent is authorized to take whatever steps are necessary or advisable to enable me to remain in my personal residence as long as it is reasonable under the circumstances. I realize that my health may deteriorate so that it becomes necessary to have round-the-clock nursing care if I am to remain in my personal residence, and I direct my Agent to obtain such care (including any equipment that might assist in such care) as is reasonable under the circumstances.

☐ If I mark this box, I do not want to be hospitalized or put in a convalescent or similar home as long as it is reasonable to maintain me in my personal residence.

8. Statement of Desires, Special Provisions and Limitations. My Agent is authorized to give, withhold, withdraw or modify consent to any and all medical, dental, nursing, and hospital care and treatment, either preventive or corrective, including major surgery and long term care deemed necessary by a duly licensed physician or dentist for my health and well being at a hospital or other licensed health care or residential facility, to include short and long term treatment facilities, convalescent centers and care homes.

9. Inspection and Disclosure of Information Relating to my Physical or Mental Health. Subject to any limitations in this document, my Agent has the power and authority to do all of the following:

9.1 Request, review, and receive any information, verbal or written, regarding my physical or mental health, including, but not limited to, medical and hospital records.

9.2 Execute on my behalf any releases or other documents that may be required in order to obtain this information.

9.3 Consent to the disclosure of this information.

9.4 HIPAA RELEASE AUTHORITY. I intend for my agent 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. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (aka HIPAA), 42 USC 1320d and 45 CFR 160-164. I authorize:

any physician, health-care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy or other covered health-care provider, any insurance company and the Medical Information Bureau Inc. or other health-care clearinghouse that has provided treatment or services to me, or that has paid for or is seeking payment from me for such services,

to give, disclose and release to my agent, without restriction,

all of my individually identifiable health information and medical records regarding any past, present or future medical or mental health condition, including (if applicable) all information relating

to the diagnosis and treatment of HIV/AIDS, sexually transmitted diseases, mental illness, and drug or alcohol abuse.

The authority given my agent shall supersede any prior agreement that I may have made with my health-care providers to restrict access to or disclosure of my individually identifiable health information. The authority given my agent has no expiration date and shall expire only in the event that I revoke the authority in writing and deliver it to my health-care provider.

10. Signing Documents, Waivers and Releases. Where necessary to implement the health care decisions that my Agent is authorized by this document to make, my Agent has the power and authority to execute on my behalf all of the following:

    10.1 Any necessary form to approve or disapprove diagnostic tests, surgical procedures, programs or medication, and orders not to resuscitate.

    10.2 Documents titled or purporting to be a "Refusal to Permit Treatment" and "Leaving Hospital Against Medical Advice."

    10.3 Any necessary waiver or release from liability required by a hospital or physician.

11. Authority to Visit. My Agent shall have the authority to visit me in any medical, nursing, residential or similar facility and may authorize other individuals who may not be related to me to visit me.

12. Admission to or Discharge from Health Care Facilities. My Agent shall have the power to authorize my admission to or discharge from any medical, nursing, residential or similar facility and to arrange, contract for, and pay for consultation, diagnosis or services as may be required for my care, without my Agent incurring any personal financial liability. My Agent is authorized to employ, compensate and discharge such medical and professional personnel including, doctors, nurses, physical therapists, medical consultants, companions, servants and employees as my Agent deems appropriate.

13. Nomination of Guardian. If a guardian of my person for any reason be appointed, I nominate my Agent (or his or her successor), named above.

PART 3

14. Organ Donation. (A) Upon my death:

☐ I do not want to make any donation

☐ I give any needed organs, tissues or parts

☐ I give the following organs, tissues, or parts only: _____
_____

(B) My gift is for the following purposes (strike any of the following you **DO NOT** want):

(I) Transplant
(II) Therapy
(III) Research
(IV) Education

PART 4

15. Designation of Primary Physician. I designate the following physician as my primary physician:

_____

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:

_____

16. Reliance on Photocopies. Any person dealing with the Agent designated hereunder shall have the right to rely on a photocopy of this Advanced Health Care Directive as if it were the signed, original Advanced Health Care Directive.

17. Prior Advance Health Care Directive Revoked. I revoke any prior Advanced Health Care Directive.

18. Witnesses. 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.

19. 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.) I direct that:

_____
_____
_____

_____
_____

I understand the full meaning of this Advanced Health Care Directive and I am emotionally and mentally competent to make this declaration.

_____ _____

Date Name:

STATE OF HAWAII)
)
) SS.
COUNTY OF MAUI)

On this ____ day of _____, 2005, before me, _____ appeared, personally known to me or satisfactorily proved to me to be the person whose name is subscribed to this instrument, and acknowledged that she/he executed the same as her/his free act and deed.

_____
Name:

Notary Public, State of Hawaii
My commission expires: