

California Medical Association
Physicians dedicated to the health of Californians

ADVANCE HEALTH CARE DIRECTIVE
Including Power of Attorney for Health Care Decisions
California Probate Code Sections 4600-4805

MY HEALTH CARE WISHES

This form lets you give instructions about your future health care. It also lets you name someone to make decisions for you if you can't make your own decisions. It's best if you fill out the whole form, but, as long as it is signed, dated and witnessed or notarized properly, you may choose only to appoint an agent (section 1) or provide health care instructions (section 5). If there is anything in this form you do not understand, read the booklet that comes with this form and the italicized instructions on the form, or ask your physician, other health care professional or an attorney for help. You may also review additional information and instructions concerning advance health care directives on the California Medical Association's website, www.cmanet.org. Internet access is available at your local public library.

1. APPOINTMENT OF HEALTH CARE AGENT

I, _____, wish to appoint a health care agent.

Fill in below the name and contact information of the person(s) (your agent and alternate agent(s)) you wish to make health care decisions for you if you are unable to make them for yourself. You may appoint alternate agents in case your first appointed agent is not willing, able or reasonably available to make these decisions when asked to do so.

Your agent may not be:

- A. Your primary treating health care provider.
- B. An operator of a community care or residential care facility where you receive care.
- C. An employee of the health care institution or community or residential care facility where you receive care, unless your agent is related to you or is one of your co-workers.

If you choose to name an agent, you should discuss your wishes with that person and give that person a copy of this form. You should make sure that this person understands your wishes and this responsibility and is willing to accept it.

OR

I, _____, do not wish to appoint an agent at this time.

If you choose not to name an agent, initial the box above, print your name on the line in the Option B above, draw a line through the next page (page 2), then continue to Section 3.

I hereby appoint as my agent to make health care decisions for me:

Name _____
(agent's name)

Address _____
(street address, city, state, zip code)

Home Phone _____ **Work Phone** _____

Cell phone/Pager _____ **Fax** _____ **e-mail** _____

I understand this appointment will continue unless I revoke it as explained in Section 3.

If I revoke my agent's authority or if my agent is not reasonably available, able or willing to make health care decisions for me, I appoint the following person(s) to do so, listed in the order they should be asked:

OPTIONAL: 1st alternate agent: Name _____ e-mail _____

Address _____ Home phone () _____
(street address, city, state, zip code)

Work Phone () _____ Cell phone/Pager () _____ Fax () _____

OPTIONAL: 2nd alternate agent: Name _____ e-mail _____

Address _____ Home phone () _____
(street address, city, state, zip code)

Work Phone () _____ Cell phone/Pager () _____ Fax () _____

2. AUTHORITY OF AGENT

*Your agent must make health care decisions that are consistent with the instructions in this document and your known desires. **It is important that you discuss your health care desires with the person(s) you appoint as your health care agent, and with your doctor(s).** If your wishes are not known, your agent must make health care decisions that your agent believes to be in your best interest, considering your personal values to the extent they are known.*

If my primary physician finds that I cannot make my own health care decisions, I grant my agent full power and authority to make those decisions for me, subject to any health care instructions set forth below. My agent will have the right to:

- A. Consent, refuse consent, or withdraw consent to any medical care or services, such as tests, drugs, surgery, or consultations for any physical or mental condition. This includes the provision, withholding or withdrawal of artificial nutrition and hydration (feeding by tube or vein) and all other forms of health care, including cardiopulmonary resuscitation (CPR).
- B. Choose or reject my physician, other health care professionals or health care facilities.
- C. Receive and consent to the release of medical information.
- D. Donate organs or tissues, authorize an autopsy and dispose of my body, unless I have said something different in a contract with a funeral home, in my will, or by some other written method.

I understand that, by law, my agent may not consent to committing me to or placing me in a mental health treatment facility, or to convulsive treatment, psychosurgery, sterilization or abortion.

OPTIONAL: I want my agent's authority to make health care decisions for me to start now, **even though I am still able to make them for myself.** I understand and authorize this statement as proved by my

signature

3. PRIOR DIRECTIVES REVOKED

I revoke any prior Power of Attorney for Health Care or Natural Death Act Declaration.

You may revoke any part of or this entire Advance Health Care Directive at any time To revoke the appointment of an agent, you must inform your treating health care provider personally or in writing. Completing a new California Medical Association Advance Health Care Directive will revoke all previous directives. If you revoke a prior directive, notify every person, physician, hospital, clinic, or care facility that has a copy of your prior directive and give them a copy of your new directive, if you execute one.

4. COPIES

My agent and others may use copies of this document as though they were originals.

Your agent may need this document immediately in case of an emergency. You should keep the completed original and give copies of the completed original to (1) your agent and alternate agents, (2) your physician(s), (3) members of your family and others who might be called in the event of a medical emergency, and (4) any hospital or other health facility where you receive treatment. Instruct your agent(s), family, and friends to provide a copy of your directive to your physician(s) or emergency medical personnel on request.

5, HEALTH CARE INSTRUCTIONS

You may, but are not required to, state your desires about the goals and types of medical care you do or do not want, including your desires concerning life support if you are seriously ill. If your wishes are not known, your agent must make health care decisions for you that your agent believes to be in your best interest, considering your personal values. If you do not wish to provide specific, written health care instructions, draw a line through this Section.

The following are statements about the use of life-support treatments. Life-support or life-sustaining treatments are any medical procedures, devices or medications used to keep you alive. Life-support treatments may include: medical devices put in you to help you breathe; food and fluid supplied artificially by medical device (feeding tube); cardiopulmonary resuscitation (CPR); major surgery; blood transfusions; kidney dialysis; and antibiotics.

Sign either of the following general statements about life-support treatments if one accurately reflects your desires. If you wish to modify or add to either statement or to write your own statement instead, you may do so in the space provided or on a separate sheet(s) of paper which you must date and sign and attach to this form.

OPTIONAL: The statement I have signed below is to apply if I am suffering from a terminal condition from which death is expected in a matter of months, or if I am suffering from an irreversible condition that renders me unable to make decisions for myself, and life-support treatments are needed to keep me alive.

A. I request that all treatments other than those needed to keep me comfortable be discontinued or withheld and my physician(s) allows me to die as gently as possible. I understand and authorize this statement as proved by my

signature

OR

B. I want my life to be prolonged as long as possible within the limits of generally accepted health care standards. I understand and authorize this statement as proved by my

signature

OPTIONAL: Other or additional statements of medical treatment desires and limitations:

For additional Advance Health Care Directive options, go to the California Medical Association k website at www.cmanet.org.

OPTIONAL: I have added _____, page(s) of specific health care instructions to this directive, each of which is signed and dated on the same day I signed this directive.

6. ORGAN AND TISSUE DONATION

I wish to be an organ donor. I understand and authorize this statement as proved by my

I have indicated this on my driver's license and/or optional section below.

If you **do not** wish to be an organ donor, please check this box:

*Organ and tissue donation represent one of the greatest gifts that an individual can make. A **clear statement of your intent, such as the information that follows, will help to make sure that your intentions regarding organ and tissue donations are honored. Be sure to communicate these intentions to your family members, loved ones, and physician(s).***

For more information on organ and tissue donation in Northern California, contact the California Transplant Donor Network at www.tdn.org or telephone 888-570-9400; in Central California, contact One Legacy, Los Angeles, CA, at www.onlegacy.com or telephone (213) 413-6219; in Eastern California, contact Golden State Donor Services, Sacramento, CA, at www.nsd.org or telephone (916) 567-1600; in Southern California, contact Lifeshare, Southern California, San Diego, CA, at www.lifesharing.org or telephone (619) 521-1983.

OPTIONAL: Other or additional statements of organ and tissue donation desires and limitations.

I, _____ make this anatomical gift to take effect upon my death:

I give

my body

any needed organ (e.g., kidneys, liver, heart, lungs, pancreas, spleen), tissue (corneas, heart valves, skin, bone) or parts

only the following organs, tissues, or parts:

to

the regional organ procurement agency or eye or tissue bank for transplantation or other therapy

the following university, hospital, storage bank, or other medical institution:

for

transplantation or treatment of any person who can medically benefit

medical education

medical research

any purpose authorized by law

I understand and authorize this statement as proved by my

signature

7. DATE AND SIGNATURE OF PRINCIPAL

I sign my name to and acknowledge this Advance Health Care Directive:

(signature of principal)

(date of birth)

(date of signing)

8. STATEMENT OF WITNESSES

*This Advance Health Care Directive will not be valid unless it is either (1) signed by two qualified adult witnesses who are present when you sign or acknowledge your signature or (2) acknowledged before a notary public in California. If you use witnesses rather than a notary public, the law **prohibits using the following as witnesses:** (1) the persons you have appointed as your agent or alternate agent(s); (2) your health care provider or an employee of your health care provider; or (3) an operator or employee of an operator of a community care facility or residential care facility for the elderly. Additionally, at least one of the witnesses **cannot** be related to you by blood, marriage or adoption, or be named in your will, or by operation of law be entitled to any portion of your estate upon your death.*

Special Rules for Skilled Nursing Facility Residents

If you are a patient in a skilled nursing facility, you must have a patient advocate or ombudsman sign as a witness and sign the Statement of Patient Advocate or Ombudsman. (See Following Pages) You must also have a second qualified witness sign below or have this document acknowledged before a notary public.

FOR SKILLED NURSING FACILITIES: STATEMENT OF PATIENT ADVOCATE OR OMBUDSMAN

If you are a patient in a skilled nursing facility, a patient advocate or ombudsman must sign the Statement of Witnesses (See Following Pages), and must also sign the following declaration.

I further declare under penalty of perjury under these laws of California that I am a patient advocate or ombudsman as designated by the State Department of Aging and am serving as a witness as required by Probate Code 4675.

Name/Title Printed

Signature

Date

Address

STATEMENT OF WITNESSES (continued)

I declare under penalty of perjury under the laws of California (1) that the individual who signed or acknowledged this Advance Health Care Directive is personally known to me, or that the individual's identity was proven to me by convincing evidence (*see next page), (2) that the individual signed or acknowledged this Advance Health Care Directive in my presence, (3) that the individual appears to be of sound mind and under no duress, fraud, or undue influence, (4) that I am not a person appointed as agent by this Advance Health Care Directive, and (5) I am not the individual's health care provider nor an employee of that health care provider, nor an operator or employee of an operator of a community care facility or a residential care facility for the elderly.

First Witness: _____
da e *am* 

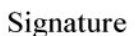
Residence Address:

Second Witness: _____
 

Residence Address:

AT LEAST ONE OF THE ABOVE WITNESSES MUST ALSO SIGN THE FOLLOWING DECLARATION:

I further declare under penalty of perjury under the laws of California that I am not related to the individual executing this Advance Health Care Directive by blood, marriage, or adoption, and, to the best of my knowledge I am not entitled to any part of the individual's estate upon his or her death under a will now existing or by operation of law.



Dae _____

9.-CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC

A acknowledgment before a notary public is not required if two qualified witnesses have signed on page 7. If you are a patient in a skilled nursing facility, you must have a patient advocate or ombudsman sign the Statement of Witnesses on page 3 and the Statement of Patient Advocate or Ombudsman above, even if you also have this form notarized.

State of California

County of

↑ ss.

On this _____, before me, _____

(ddfe)

personally appeared _____

(name(s) of signer(s))

personally known to me (or proved to me on the basis of satisfactory evidence) to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/s he/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

WITNESS my hand and official seal.

(signature of notary)

Notary Seal

Additional forms can be purchased from:

CMA Publications, 1201 J Street, Suite 375, Sacramento, CA 95814-2905

Phone: 1-800-882-1262 • Fax: 916-551-2035 • Internet: www.emanet.org

*EVIDENCE OF IDENTITY The following forms of identification are satisfactory evidence of identity: a California driver's license or identification card or U.S. passport that is current or has been issued within five years, or any of the following if the document is current or has been issued within 5 years, contains a photograph and description of the person named on it, is signed by the person, and bears a serial or other identifying number: a foreign passport that has been stamped by the U.S. Immigration and Naturalization Service; a driver's license issued by another state or by an authorized Canadian or Mexican agency; an identification card issued by another state or by any branch of the U.S. armed forces, or for an inmate in custody, an inmate identification card issued by the Department of Corrections. If the principal is a patient in a skilled nursing facility, a patient advocate or ombudsman may rely on the representations of family members or the administrator or staff of the facility as convincing evidence of identity if the patient advocate or ombudsman believes that the representations provide a reasonable basis for determining the identity of the principal.

AUTHORITY TO INSPECT/ RELEASE MEDICAL INFORMATION:

authorize that my agent(s):

shall be my personal representative under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). As such, my agent has the same rights to inspect and obtain copies of any medical or other health information as I would have. My agent also has the right to authorize disclosure of my patient records and other medical or health information subject to and protected under HIPAA. Pursuant to the California Confidentiality of Medical Information Act (CMIA) and California Probate Code §4678, my agent has the same rights to request, receive, examine, copy and consent to the disclosure of my medical or other health care information as I would have. This authority applies to any individually identifiable health or medical information, health care information or other medical records governed by HIPAA, CMIA or California Probate Code §4678.

(Signature)

STATE OF CALIFORNIA

SS.

COUNTY OF ORANGE

On _____, 2004, before me, _____, Notary Public, personally appeared _____, personally known to me or proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to the within instrument, and acknowledged to me that she executed the same in her authorized capacity, and that by her signature on the instrument the person or the entity upon behalf of which the person acted, executed the instrument.

WITNESS my hand and official seal.

(This space reserved for official notarial seal.).

