PART I DURABLE HEALTH CARE POWER OF ATTORNEY

I _____, of _____ County, Pennsylvania, appoint the person named below to be my health care agent to make health and personal care decisions for me whenever I cannot understand, make or communicate a choice regarding a health or personal care decision as verified by my attending physician. My health care agent may not delegate the authority to make decisions.

APPOINTMENT OF HEALTH CARE AGENT

I appoint the following

Health Care Agent (Name and relationship): _____

Address: _____

Telephone Numbers: Home _____ Other_____

You may not appoint your doctor or other health care provider as your health care agent unless related to you by blood, marriage or adoption.

If my health care agent is not readily available or if my health care agent is my spouse and an action for divorce is filed by either of us after the date of this document, I appoint the person or persons named below in the order named.

First Alternative Health Care Agent (name and relationship): _____

Address: _____

Telephone Numbers: Home: _____ Other: _____

Second Alternative Health Care Agent (name and relationship): _____

Address: _____

Telephone Number: Home: _____ Other: _____

My health care agent has all of the following powers ***(cross out and initial any powers you do not want to give your health care agent):***

1. To **authorize, withhold or withdraw** medical care and surgical procedures.

2. To **authorize, withhold or withdraw nutrition (food) or hydration (water) medically supplied by tube through my nose, stomach, intestines, arteries or veins.**

3. To authorize my admission to or discharge from a medical, nursing, residential or similar facility and to make agreements for my care and health insurance for my care, including hospice and/or palliative care.

4. To hire and fire medical, social service and other support personnel responsible for my care.

5. To take any legal action necessary to do what I have directed.

6. To request that a physician responsible for my care issue a do-not-resuscitate (DNR) order, including an out-of-hospital DNR order, a Physician Order for Life-Sustaining Treatment (POLST), and sign any required documents and consents, including funeral and disposition of my body.

HIPAA

Effective immediately and continuously until my death or revocation by a writing signed by me or someone authorized to make health care treatment decisions for me, I authorize all health care providers or other covered entities to disclose to my health care agent, upon my agent's request, any information, oral or written, regarding my physical or mental health, including, but not limited to, medical and hospital records and what is otherwise private, privileged, protected or personal health information, such as health information as defined and described in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the regulations issued under and any other State or local laws and rules.

PART II HEALTH CARE TREATMENT INSTRUCTIONS IN THE EVENT OF END- STAGE MEDICAL CONDITION OR PERMANENT UNCONSCIOUSNESS (LIVING WILL)

The following health care treatment instructions exercise my right to make my own health care decisions. The intent of these instructions is to provide clear and convincing evidence of my wishes to be followed when I cannot understand, make or communicate my treatment decisions:

END- STAGE MEDICAL CONDITION OR PERMANENT UNCONSCIOUSNESS

If I have an end-stage medical condition (which will result in my death, despite the introduction or continuation of medical treatment) or am permanently unconscious such as an irreversible coma or an irreversible vegetative state and there is no realistic hope of significant recovery, then I choose the following ***(Initial only one statement)***

Initials_____ **I do want** all medical and surgical treatment needed to keep me alive, even though my doctor believes that it will only delay my death or keep me in a state of permanent unconsciousness.

Initials_____ **I do not want** aggressive medical care, and give the following instructions ***(cross out and initial any treatment instructions with which you do not agree):***

1. I direct that I be given health care treatment to relieve my pain or provide comfort even if such treatment might shorten my life, suppress my appetite or my breathing, or be habit forming.

2. I direct that all life prolonging procedures be withheld or withdrawn.

3. I specifically do not want any of the following as life prolonging procedures: heart-lung resuscitation (CPR), mechanical ventilation (breathing machine), dialysis (kidney machine), surgery, chemotherapy, radiation treatment or antibiotics.

TUBE FEEDING

I have indicated below, by my initials, whether I want nutrition (food) or hydration (water) medically supplied by a tube into my nose, stomach, intestine, arteries, or veins if I have an end-stage medical condition or I am permanently unconscious and there is no realistic hope of significant recovery. ***(Initial only one statement)***

Initials_____ **I do want** tube feedings to be given.

OR

Initials_____ **I do not want** tube feedings to be given.

HEALTH CARE AGENT'S USE OF INSTRUCTIONS *(Initial only one statement)*

Initials_____ My health care agent **must follow** these instructions.

OR

Initials_____ These instructions are **only guidance.** My health care agent shall have final say and may override any of my instructions. *(Indicate below any desired limitation of agent's authority.)*

LEGAL PROTECTION

Pennsylvania law protects my health care agent and health care providers from any legal liability for their good faith actions in following my wishes as expressed in this form or in complying with my health care agent's direction. On behalf of myself, my executors and heirs, I further hold my health care agent and my health care providers harmless and indemnify them against any claim for their good faith actions in recognizing my health care agent's authority or in following my treatment instructions.

ORGAN DONATION *(Initial only one statement)*

_____ I **do consent** to donate my organs and tissues at the time of my death for the purpose of **transplant, medical study or education.** *(Insert any limitations you desire on donation of specific organs or tissues for donation of organs and tissues.)*_____

OR

_____ I **do not consent** to donate my organs or tissues at the time of my death.

SIGNATURE

Having carefully read this document, I have signed it this _____day of _____, 20____, revoking all previous health care powers of attorney and health care treatment instructions.

Signature: _____ Date of Birth: _____

Address: _____

Witness: _____ Witness: _____

Pennsylvania law requires two witnesses at least 18 years of age to witness your signature in each other's presence. A person who signs this document on behalf of and at the direction of a principal may not be a witness. (It is preferable if the witnesses are not your heirs, nor your creditors, nor employed by any of your health care providers.)

NOTARIZATION (OPTIONAL)

Notarization of document is not required by Pennsylvania law, but if the document is both witnessed and notarized, it is more likely to be honored by the laws of some other states.

On this _____day of _____, 20____, before me personally appeared the aforesaid declarant and principal, to me known to be the person described in and who executed the foregoing instrument and acknowledged that he/she executed the same as his/her free act and deed.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal in the County of _____, State of _____the day and year first above written.

Notary Public _____ My commission expires on _____

IF YOU DESIRE A WALLET CARD. PLEASE COMPLETE AND CUT OUT THE CARD BELOW. PUT A COPY OF THIS CARD IN THE WALLET OR PURSE YOU CARRY MOST OFTEN, ALONG WITH YOUR MEDICAL INSURANCE CARD AND DRIVER'S LICENSE.

----------**CUT HERE** ----------

ADVANCE HEALTH CARE DIRECTIVE IDENTIFICATION CARD

Name:_____

I have a Health Care Power of Attorney and a Living Will.
If I am unable to speak for myself, please contact:

_____ _____
Agent Telephone No.

_____ _____
1st Alternative Agent Telephone No.

_____ _____
Primary Care Physician Telephone No.

**Fill out this card and keep it in your wallet with your medical insurance card and driver's license.*