

INTRODUCTORY REMARKS ON HEALTH CARE DECISION MAKING

YOU HAVE THE RIGHT TO DECIDE THE TYPE OF HEALTH CARE YOU WANT. SHOULD YOU BECOME UNABLE TO MAKE OR COMMUNICATE DECISIONS ABOUT MEDICAL CARE, YOUR WISHES FOR MEDICAL TREATMENT ARE MOST LIKELY TO BE FOLLOWED IF YOU EXPRESS THOSE WISHES IN ADVANCE BY:

- (1) NAMING AN AGENT TO DECIDE TREATMENT FOR YOU; AND
- (2) GIVING HEALTH CARE TREATMENT INSTRUCTIONS TO YOUR AGENT OR HEALTH CARE PROVIDER.

AN ADVANCE HEALTH CARE DIRECTIVE IS A WRITTEN SET OF INSTRUCTIONS EXPRESSING YOUR WISHES FOR MEDICAL TREATMENT. IT MAY CONTAIN A HEALTH CARE POWER OF ATTORNEY, WHERE YOU NAME A PERSON CALLED AN "AGENT" TO DECIDE TREATMENT FOR YOU, AND A LIVING WILL, WHERE YOU TELL YOUR AGENT AND HEALTH CARE PROVIDERS TO LIMIT HEALTH CARE TREATMENTS IF YOU ARE TERMINALLY ILL OR PERMANENTLY UNCONSCIOUS.

YOU MAY LIMIT YOUR AGENT'S INVOLVEMENT IN DECIDING YOUR MEDICAL TREATMENT SO THAT YOUR AGENT WILL SPEAK FOR YOU ONLY WHEN YOU ARE UNABLE TO SPEAK FOR YOURSELF. YOU, AND NOT YOUR AGENT, REMAIN RESPONSIBLE FOR THE COST OF YOUR MEDICAL CARE.

IF YOU DO NOT WRITE DOWN YOUR WISHES ABOUT YOUR HEALTH CARE IN ADVANCE, AND IF LATER YOU BECOME UNABLE TO MAKE OR COMMUNICATE THESE DECISIONS, THOSE WISHES MAY NOT BE HONORED BECAUSE THEY MAY REMAIN UNKNOWN TO OTHERS.

A HEALTH CARE PROVIDER WHO REFUSES TO HONOR YOUR WISHES ABOUT HEALTH CARE MUST TELL YOU OF ITS REFUSAL AND HELP TO TRANSFER YOU TO A HEALTH CARE PROVIDER WHO WILL HONOR YOUR WISHES.

YOU SHOULD GIVE A COPY OF YOUR ADVANCE HEALTH CARE DIRECTIVE (A LIVING WILL, HEALTH CARE POWER OF ATTORNEY OR A DOCUMENT CONTAINING BOTH) TO YOUR AGENT, YOUR PHYSICIAN AND OTHERS WHOM YOU EXPECT WOULD LIKELY ATTEND TO YOUR NEEDS IF YOU BECOME UNABLE TO MAKE OR COMMUNICATE DECISIONS ABOUT MEDICAL CARE.

IF YOUR HEALTH CARE WISHES CHANGE, TELL YOUR PHYSICIAN AND WRITE A NEW ADVANCE HEALTH CARE DIRECTIVE TO REPLACE YOUR OLD ONE.

YOU MAY WISH TO CONSULT WITH KNOWLEDGEABLE, TRUSTED INDIVIDUALS SUCH AS FAMILY MEMBERS, YOUR PHYSICIAN OR CLERGY WHEN CONSIDERING AN EXPRESSION OF YOUR VALUES AND HEALTH CARE WISHES. YOU ARE FREE TO CREATE YOUR OWN ADVANCE HEALTH CARE DIRECTIVE TO CONVEY YOUR WISHES REGARDING MEDICAL TREATMENT.

THE FOLLOWING IS AN ADVANCE HEALTH CARE DIRECTIVE THAT COMBINES A HEALTH CARE POWER OF ATTORNEY WITH A LIVING WILL.

NOTES ABOUT THE USE OF THIS FORM:

If you decide to use this form or create your own advance health care directive, you should consult with your physician and your attorney to make sure that your wishes are clearly expressed and comply with the law.

If you decide to use this form but disagree with any of its statements, you may cross out those statements. You may add comments to this form or your own form to help your physician or agent decide your medical care.

This form is designed to give your agent broad powers to make health care decisions for you whenever you cannot make them for yourself. It is also designed to express a desire to limit care if you suffer from an end-stage medical condition or are permanently unconscious.

If you do not desire to give your agent broad powers, or you do not wish to limit your care if you have an end-stage medical condition or are permanently unconscious, you may wish to use a different form or create your own. You should also use a different form if you wish to express your preferences in more detail than this form allows. In these situations, it is particularly important that you consult with your attorney and physician to make sure that your wishes are clearly expressed.

This form allows you to tell your agent your goals if you have an end-stage medical condition or other extreme and irreversible medical condition, such as advanced Alzheimer's disease. Do you want medical care applied aggressively in these situations or would you consider such aggressive medical care burdensome and undesirable?

You may choose whether you want your agent to be bound by your instructions or whether you want your agent to be able to decide at the time what course of treatment the agent thinks most fully reflects your wishes and values.

If you are a woman and diagnosed as being pregnant at the time a health care decision would otherwise be made pursuant to this form, the laws of Pennsylvania prohibit implementation of that decision if it directs that life-sustaining treatment, including nutrition and hydration, be withheld or withdrawn from you, unless your attending physician and an obstetrician who have examined you certify in your medical record that the life-sustaining treatment:

- (1) Will not maintain you in such a way as to permit the continuing development and live birth of the unborn child;
- (2) Will be physically harmful to you; or
- (3) Will cause pain to you that cannot be alleviated by medication.

A physician is not required to perform a pregnancy test on you unless the physician has reason to believe that you may be pregnant.

Pennsylvania law protects your agent and health care providers from any legal liability for following in good faith your wishes as expressed in the form or by your agent's direction. It does not otherwise change professional standards or excuse negligence in the way your wishes are carried out. If you have any questions about the law, consult an attorney for guidance.

This form and explanation is not intended to take the place of specific legal or medical advice for which you should rely upon your own attorney and physician.

**DURABLE HEALTH CARE POWER OF ATTORNEY AND HEALTH CARE
TREATMENT INSTRUCTIONS (LIVING WILL)
DURABLE HEALTH CARE POWER OF ATTORNEY**

APPOINTMENT OF AGENT:

I, _____, of _____, _____ County, Pennsylvania, appoint the person named below to be my agent to make health and personal care decisions for me.

HEALTH CARE AGENT:

(Name and Relationship) _____

ADDRESS: _____

TELEPHONE NUMBER: HOME: _____

WORK: _____

E-MAIL ADDRESS: _____

- You are not required to appoint an agent. If you do not wish to appoint an agent, write "NONE" in the above space. If you do not name an agent, health care providers will ask your family or an adult who knows your preferences and values for help in determining your wishes for treatment.
- Note that you may not appoint your doctor or other healthcare provider as your agent unless related to you by blood, marriage or adoption.

ALTERNATIVE AGENTS:

If my agent is not readily available, willing or able to serve as my agent, or if my 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. (It is helpful, but not required, to name alternative agents.)

ALTERNATIVE HEALTH CARE AGENT:

(Name and Relationship) _____

ADDRESS: _____

TELEPHONE NUMBER: HOME: _____

WORK: _____

E-MAIL ADDRESS: _____

ALTERNATIVE HEALTH CARE AGENT:

(Name and Relationship) _____

ADDRESS: _____

TELEPHONE NUMBER: HOME: _____

WORK: _____

E-MAIL ADDRESS: _____

MEDICAL RELEASE:

Effective immediately and continuously until my death or revocation, I authorize all health care providers or other covered entities to disclose to my 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 (Public Law 104-191, 110 stat. 1936/2024), the regulations promulgated thereunder and any other state or local laws and rules. Information disclosed by a health care provider or other covered entity may be redisclosed and may no longer be subject to the privacy rules provided by 45 C.F.R. pt. 164.

AGENT’S POWERS:

The remainder of this document will take effect when and only when I lack sufficient capacity to make or communicate a choice regarding a health or personal care decision as verified by my attending physician. My agent may not delegate the authority to make decisions.

My agent has **all of the following powers** subject to the health care treatment instructions that follow **(cross out and initial any powers you do not want to give your 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 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, and sign any required documents and consents.

GUIDANCE FOR HEALTH CARE AGENT:

If I have an end-stage medical condition or other extreme irreversible medical condition, my goals in making medical decisions are as follows (insert your personal priorities such as comfort, care, preservation of mental function, etc.)

SEVERE BRAIN DAMAGE OR BRAIN DISEASE:

If I should suffer from severe and irreversible brain damage or brain disease with no realistic hope of significant recovery, I would consider such a condition intolerable and the application of aggressive medical care to be burdensome.

I therefore request that my agent respond to any intervening (other and separate) life-threatening conditions in the same manner as directed for an end-stage medical condition or state of permanent unconsciousness as I have indicated below.

INITIALS _____ I AGREE

INITIALS _____ I DISAGREE

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

The following health care treatment instructions exercise my right to make decisions concerning my health care. These instructions are intended to provide clear and convincing evidence of my wishes to be followed when I lack the capacity to make or communicate my treatment decisions:

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 in an irreversible coma or irreversible vegetative state and there is no realistic hope of significant recovery, all of the following apply (**cross out and initial any treatment instructions with which you do not agree**):

GENERAL PROVISIONS:

I DIRECT THAT I BE GIVEN HEALTH CARE TREATMENT TO RELIEVE PAIN OR PROVIDE COMFORT EVEN IF SUCH TREATMENT MIGHT SHORTEN MY LIFE, SUPPRESS MY APPETITE OR MY BREATHING, OR BE HABIT FORMING.

I DIRECT THAT ALL LIFE PROLONGING PROCEDURES BE WITHHELD OR WITHDRAWN.

SPECIFIC PROVISIONS:

I **SPECIFICALLY DO NOT WANT** ANY OF THE FOLLOWING AS LIFE PROLONGING PROCEDURES: (IF YOU WISH TO RECEIVE ANY OF THESE TREATMENTS, WRITE "I DO WANT" AFTER THE TREATMENT.)

- HEART-LUNG RESUSCITATION (CPR) _____
- MECHANICAL VENTILATOR (BREATHING MACHINE) _____
- DIALYSIS (KIDNEY MACHINE) _____
- SURGERY _____
- CHEMOTHERAPY _____
- RADIATION TREATMENT _____
- ANTIBIOTICS _____
- BLOOD OR BLOOD PRODUCTS _____
- INVASIVE DIAGNOSTIC TESTING _____

TUBE FEEDINGS AND HYDRATION (INITIAL ONE OPTION ONLY):

Please indicate whether you want nutrition (food) or hydration (water) medically supplied by a tube into your nose, stomach, intestine or veins if you have an end-stage medical condition or are permanently unconscious and there is no realistic hope of significant recovery.

_____ I **want** tube feedings/hydration to be given

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

HEALTH CARE AGENT'S USE OF INSTRUCTIONS (INITIAL ONE OPTION ONLY):

_____ My agent **must follow** these instructions.

OR

_____ These instructions are **only guidance**. My agent shall have final say and may override any of my instructions. (Indicate any exceptions) _____

INDEMNIFICATION/LEGAL PROTECTION:

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

ORGAN DONATION (INITIAL ONE OPTION ONLY):

_____ I **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 or uses for donation of organs and tissues.) _____

OR

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

HAVING CAREFULLY READ THIS DOCUMENT, I HAVE SIGNED IT THIS _____ DAY OF _____, 201__, REVOKING ALL PREVIOUS HEALTH CARE POWERS OF ATTORNEY AND MEDICAL TREATMENT INSTRUCTIONS.

SIGNED: _____
Printed Name:

WITNESS: _____ ADDRESS: _____

WITNESS: _____ ADDRESS: _____

[Two witnesses at least 18 years of age are required by Pennsylvania law and should 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.)]

COMMONWEALTH OF PENNSYLVANIA :
: SS
COUNTY OF _____ :

ON THIS _____ day of _____, 201__, before me personally appeared _____, the aforesaid declarant, 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 the day and year first above written.

Notary Public

My commission expires

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.