|  |
| --- |
| **Part I: Selection of Health Care Agent** |

**By:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Print Name)

**Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**A. Selection of Primary Agent**

I select the following individual as my agent to make health care decisions for me (usually spouse if married):

**Name:**

**Address:**

**Telephone Numbers:**

(home and cell)

**B. Selection of Back-up Agents**

(Optional)

1. If my primary agent cannot be contacted in time or for any reason is unavailable or unable or unwilling to act as my agent, then I select the following person to act in this capacity:

**Name:**

**Address:**

**Telephone Numbers:**

(home and cell)

2. If my primary agent and my first back-up agent cannot be contacted in time or for any reason are unavailable or unable or unwilling to act as my agent, then I select the following person to act in this capacity:

**Name:**

**Address:**

**Telephone Numbers:**

(home and cell)

**C. People My Agent Should Consult**

(**Optional**)

In making important decisions on my behalf, I encourage my agent to consult with the following people. By filling this in, I do not intend to limit the number of people with whom my agent might want to consult or my agent’s power to make decisions.

**Name(s) Telephone Number(s):**

|  |  |  |
| --- | --- | --- |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**D. Access to my Health Information – Federal Privacy Law (HIPAA) Authorization**

1. If, prior to the time the person selected as my agent has power to act under this document, my doctor wants to discuss with that person my capacity to make my own health care decisions, I authorize my doctor to disclose protected health information which relates to that issue.

2. Once my agent has full power to act under this document, my agent may request, receive, and review any information, oral or written, regarding my physical or mental health, including, but not limited to, medical and hospital records and other protected health information, and consent to disclosure of this information.

3. For all purposes related to this document, my agent is my personal representative under the Health Insurance Portability and Accountability Act (HIPAA). My agent may sign, as my personal representative, any release forms or other HIPAA-related materials.

Other than your Primary Health Care Agent or Successor Health Care Agent(s), individuals, if any, you would like to authorize to receive information about you:

Name and Relationship :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**E. Effectiveness of this Part**

(Read both of these statements carefully. Then, initial one only.)

My agent’s power is in effect:

1. Immediately after I sign this document, subject to my right to make any decision about my health care if I want and am able to.

✎\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**>>OR<<**

2. Whenever I am not able to make informed decisions about my health care, either because the doctor in charge of my care (attending physician) decides that I have lost this ability temporarily, or my attending physician and a consulting doctor agree that I have lost this ability **permanently**.

✎\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **Part II: Treatment Preferences (“Living Will”)** |

**A. Statement of Goals and Values**

**(This statement is Optional)**

I want to say something about my goals and values, and especially what’s most important to me during the last part of my life:

|  |
| --- |
|  |
|  |
|  |
|  |

**B. Preference in Case of Terminal Condition**

(If you want to state what your preference is, initial **one** only. If you do not want to state a preference here, cross through the whole section.)

**If my doctors certify that my death from a terminal condition is imminent, even if life-sustaining procedures are used:**

1. Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means.

✎\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**>>OR<<**

2. Keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means.

✎\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**>>OR<<**

3. Try to extend my life for as long as possible, using all available interventions that in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical means.

✎\_\_\_\_\_\_\_\_\_\_\_\_\_

**C. Preference in Case of Persistent Vegetative State**

(If you want to state what your preference is, initial **one** only. If you do not want to state a preference here, cross through the whole section.)

**If my doctors certify that I am in a persistent vegetative state, that is, if I am not conscious and am not aware of myself or my environment or able to interact with others, and there is no reasonable expectation that I will ever regain consciousness:**

1. Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means.

✎\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**>>OR<<**

2. Keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means.

✎\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**>>OR<<**

3. Try to extend my life for as long as possible, using all available interventions that in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical means.

✎\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**D.** **Preference in Case of End-Stage Condition**

(If you want to state what your preference is, initial **one** only. If you do not want to state a preference here, cross through the whole section.)

**If my doctors certify that I am in an end-stage condition, that is, an incurable condition that will continue in its course until death and that has already resulted in loss of capacity and complete physical dependency:**

1. Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means.

✎\_\_\_\_\_\_\_\_\_\_\_\_\_

**>>OR<<**

2. Keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means.

✎\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**>>OR<<**

3. Try to extend my life for as long as possible, using all available interventions that in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical means.

✎\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**E.** **Pain Relief**

No matter what my condition, give me the medicine or other treatment I need to relieve pain.

**F.** **Effect of Stated Preferences**

(Read both of these statements carefully. Then, initial **one** only.)

1. I realize I cannot foresee everything that might happen after I can no longer decide for myself. My stated preferences are meant to guide whoever is making decisions on my behalf and my health care providers, but I authorize them to be flexible in applying these statements if they feel that doing so would be in my best interest.

✎\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**>>OR <<**

2. I realize I cannot foresee everything that might happen after I can no longer decide for myself. Still, I want whoever is making decisions on my behalf and my health care providers to follow my stated preferences exactly as written, even if they think that some alternative is better.

✎\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **After My Death**  (The sections below are **OPTIONAL**. Do only what reflects your wishes.) |

|  |
| --- |
| **Part I: Organ Donation** |

(Initial the ones that you want. Cross through any that you do not want.)

Upon my death I wish to donate: ✎

Any needed organs, tissues, or eyes. ✎

Only the following organs, tissues or eyes:

|  |
| --- |
|  |
|  |
|  |

*I authorize the use of my organs, tissues, or eyes:*

For transplantation ✎

For therapy ✎

For research ✎

For medical education ✎

For any purpose authorized by law ✎

I understand that no vital organ, tissue, or eye may be removed for transplantation until after I have been pronounced dead. *This document is not intended to change anything about my health care while I am still alive.*  After death, I authorize any appropriate support measures to maintain the viability for transplantation of my organs, tissues, and eyes until organ, tissue, and eye recovery has been completed. I understand that my estate will not be charged for any costs related to this donation.

|  |
| --- |
| **Part II: Donation of Body** |

After any organ donation indicated in Part I, I wish my body to be donated for use in a medical study program.

✎\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **Part III: Disposition of Body and Funeral Arrangements** |

I want the following person to make decisions about the disposition of my body and my funeral arrangements: (Either initial the first or fill in the second.)

The health care agent who I named in my advance directive.

✎\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**>>OR<<**

This person:

Name:

Address:

Telephone Number(s): (Home and Cell)

If I have written my wishes below, they should be followed. If not, the person I have named should decide based on conversations we have had, my religious or other beliefs and values, my personality, and how I reacted to other peoples’ funeral arrangements. My wishes about the disposition of my body and my funeral arrangements are:

|  |
| --- |
|  |
|  |
|  |
|  |

**AFTER MY DEATH**

**Part II: Donation of Body**

The State Anatomy Board, a unit of the Department of Health administers a statewide Body Donation Program. Anatomical Donation allows individuals to dedicate the use of their bodies upon death to advance medical education, clinical and allied-health training and research study to Maryland’s medical study institutions. The Anatomy Board requires individuals to pre-register prior to death as an anatomical donor to the state Body Donation Program. There are no medical restrictions or qualifications to becoming a “Body Donor”. At death the Board will assume the custody and control of the body for study use. It is truly a legacy left behind for others to have healthier lives. For donation information and forms you can contact the Board toll-free at 800.879.2728