

ADVANCE HEALTH-CARE DIRECTIVE

Explanation

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 form lets you do either or both of these things. It also lets you express your wishes regarding the designation of your primary physician. If you use this form, you may complete or modify all or any part of it. You are free to use a different form.

Part 1 of this form is a power of attorney for health care. Part 1 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 the form you sign limits the authority of your agent, your agent may make all health-care decisions for you. This form 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. If you choose not to limit the authority of your agent, your agent will have the right to:

- (a) Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition;
- (b) Select or discharge health-care providers and institutions;
- (c) Approve or disapprove diagnostic tests, surgical procedures, programs of medication, and orders not to resuscitate; and
- (d) Direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care.

Part 2 of this form lets you give specific instructions about any aspect of your health care. Choices are provided for 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. Space is provided for you to add to the choices you have made or for you to write out any additional wishes.

Part 3 of this form lets you designate a physician to have primary responsibility for your health care.

Part 4 of this form lets you authorize the donation of your organs at your death, and declares that this decision will supersede any decision by a member of your family.

After completing this form, sign and date the form at the end and have the form witnessed by one of the two alternative methods listed below. Give a copy of the signed and completed form to your physician, to any other health-care providers you may have, to any health-care institution at which you are receiving care, and to any health-care agents you have named. You should talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take the responsibility.

You have the right to revoke this advance health-care directive or replace this form at any time.

PART 1

POWER OF ATTORNEY FOR HEALTH CARE

(1) DESIGNATION OF AGENT: I designate the following individual as my agent to make health-care decisions for me:

(name of individual you choose as agent)

(address) (city) (state) (zip code)

(home phone) (work phone)

OPTIONAL: If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health-care decision for me, I designate as my first alternate agent:

(name of individual you choose as first alternate agent)

(address) (city) (state) (zip code)

(home phone) (work phone)

OPTIONAL: If I revoke the authority of my agent and first alternate agent or if neither is willing, able, or reasonably available to make a health-care decision for me, I designate as my second alternate agent:

(name of individual you choose as second alternate agent)

(address) (city) (state) (zip code)

(home phone) (work phone)

(2) AGENT'S AUTHORITY: My agent is authorized to make all health-care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration, and all other forms of health care to keep me alive, except as I state here:

(Add additional sheets if needed.)

(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.

(4) **AGENT'S OBLIGATION:** My agent shall make health-care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health-care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

(5) **NOMINATION OF GUARDIAN:** If a guardian of my person, guardian of my estate, or conservator needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able, or reasonably available to act as guardian, I nominate the alternate agents whom I have named, in the order designated.

(6) **HIPAA and MEDICAL RECORD 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 ("HIPAA"), 42 U.S.C. § 1320(d) and 45 C.F.R. 160-164 and to any medical record and medical information, the use and/or disclosure of which is restricted by state law, including, without limitation, alcohol/drug abuse and treatment records (Miss. Code Ann. §41-30-33), HIV or Hepatitis B status (Miss. Code Ann. §41-34-7), and mental health records (Miss. Code Ann. §41-21-97). I authorize any physician, health-care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy or other covered entity 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, to include all information relating to the diagnosis and treatment of HIV/AIDS or hepatitis B, sexually transmitted diseases, mental illness and treatment, and drug or alcohol abuse and treatment. The authority given my agent in this section shall supercede any prior agreement that I may have made with any healthcare provider to restrict access to or disclosure of my individually identifiable health information and shall operate as my express written consent for disclosure of these records pursuant to state law. 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; however, if my consent and the authority granted in this paragraph is required to have an expiration date

in order to constitute a valid authorization or consent, then my consent shall be deemed to expire seven (7) years from my date of death.

PART 2

INSTRUCTIONS FOR HEALTH CARE

If you are satisfied to allow your agent to determine what is best for you in making end-of-life decisions, you need not fill out this part of the form. If you do fill out this part of the form, you may strike any wording you do not want.

(7) END-OF-LIFE DECISIONS: I direct that my health-care providers 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.

(8) ARTIFICIAL NUTRITION AND HYDRATION: Artificial nutrition and hydration must be provided, withheld or withdrawn in accordance with the choice I have made in paragraph (7) 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 (7).

(9) RELIEF FROM PAIN: Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death: _____

(10) 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:

(Add additional sheets if needed.)

PART 3

PRIMARY PHYSICIAN

(OPTIONAL)

(11) I designate the following physician as my primary physician:

(name of physician)

(address) (city) (state) (zip code)

(phone)

OPTIONAL: 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:

(name of physician)

(address) (city) (state) (zip code)

(phone)

(12) EFFECT OF COPY: A copy of this form has the same effect as the original.

PART 4

CERTIFICATE OF AUTHORIZATION FOR ORGAN DONATION (OPTIONAL)

I, the undersigned, this _____ day of _____, 20_____,
desire that my _____ organ(s) be made available after my demise for:

(a) Any licensed hospital, surgeon or physician, for medical education, research, advancement of medical science, therapy or transplantation to individuals;

(b) Any accredited medical school, college or university engaged in medical education or research, for therapy, educational research or medical science purposes or any accredited school of mortuary science;

(c) Any person operating a bank or storage facility for blood, arteries, eyes, pituitaries, or other human parts, for use in medical education, research, therapy or transplantation to individuals;

(d) The donee specified below, for therapy or transplantation needed by him or her, do donate my _____ for that purpose to _____ (name) at _____ (address).

I authorize a licensed physician or surgeon to remove and preserve for use my _____ for that purpose.

I specifically provide that this declaration shall supersede and take precedence over any decision by my family to the contrary.

Witnessed this _____ day of _____, 20_____.

(donor)

(address)

(telephone)

(witness)

(witness)

(13) SIGNATURES: Sign and date the form here:

(date)

(sign your name)

(address)

(print your name)

(city) (state)

(14) WITNESSES: This power of attorney will not be valid for making health-care decisions unless it is either (a) signed by two (2) 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.

ALTERNATIVE NO. 1

Witness

I declare under penalty of perjury pursuant to [Section 97-9-61](#), Mississippi Code of 1972, that the principal is personally known to me, that the principal signed or acknowledged this power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud or undue influence, that I am not the person appointed as agent by this document, and that I am not a health-care provider, nor an employee of a health-care provider or facility. I am not related to the principal by blood, marriage or adoption, and to the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

(date)

(signature of witness)

(address)

(printed name of witness)

(city) (state)

Witness

I declare under penalty of perjury pursuant to [Section 97-9-61](#), Mississippi Code of 1972, that the principal is personally known to me, that the principal signed or acknowledged this power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud or undue influence, that I am not the person appointed as agent by this document, and that I am not a health-care provider, nor an employee of a health-care provider or facility.

(date)

(signature of witness)

(address)

(printed name of witness)

(city) (state)

ALTERNATIVE NO. 2

State of Mississippi

County of _____

On this _____ day of _____, in the year _____, before me, _____ (insert name of notary public) appeared _____, personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this instrument, and acknowledged that he or she executed it. I declare under the penalty of

perjury that the person whose name is subscribed to this instrument appears to be of sound mind and under no duress, fraud or undue influence.

Notary Seal

(Signature of Notary Public)