ADVANCE DIRECTIVE FOR HEALTH CARE

(Living Will and Health Care Proxy)

This form may be used in the State of Alabama to make your wishes known about what medical treatment or other care you **would** or **would not** want if you become too sick to speak for yourself. You are not required to have an advance directive. If you do have an advance directive, be sure that your doctor, family, and friends know you have one and know where it is located.

Section 1. Living Will

I,____________________, being of sound mind and at least 19 years old, would like to make the following wishes known. I direct that my family, my doctors and health care workers, and all others follow the directions I am writing down. I know that at any time I can change my mind about these directions by tearing up this form and writing a new one. I can also do away with these directions by tearing them up and by telling someone at least 19 years of age of my wishes and asking him or her to write them down.

I understand that these directions will only be used if I am not able to speak for myself.

If I become terminally ill or injured:

Terminally ill or injured is when my doctor and another doctor decide that I have a condition that cannot be cured and that I will likely die in the near future from this condition.

Life sustaining treatment – Life sustaining treatment includes drugs, machines, or medical procedures that would keep me alive but would not cure me. I know that even if I choose not to have life sustaining treatment, I will still get medicines and treatments that ease my pain and keep me comfortable.

Place your initials by either "yes" or "no":

I want to have life sustaining treatment if I am terminally ill or injured._____Yes___No

Artificially provided food and hydration (Food and water through a tube or an IV) – I understand that if I am terminally ill or injured I may need to be given food and water through a tube or an IV to keep me alive if I can no longer chew or swallow on my own or with someone helping me.

Place your initials by either "yes" or "no":

I want to have food and water provided through a tube or an IV if I am terminally ill or injured.
____ Yes_____No

If I Become Permanently Unconscious:

Permanent unconsciousness is when my doctor and another doctor agree that within a reason- able degree of medical certainty I can no longer think, feel anything, knowingly move, or be aware of being alive. They believe this condition will last indefinitely without hope for improvement and have watched me long enough to make that decision. I understand that at least one of these doctors must be qualified to make such a diagnosis.

Life sustaining treatment – Life sustaining treatment includes drugs, machines, or other medical procedures that would keep me alive but would not cure me. I know that even if I choose not to have life sustaining treatment, I will still get medicines and treatments that ease my pain and keep me comfortable.

Place your initials by either “yes” or “no”:

I want to have life-sustaining treatment if I am permanently unconscious._____Yes______No

Artificially provided food and hydration (Food and water through a tube or an IV) – I understand that if I become permanently unconscious, I may need to be given food and water through a tube or an IV to keep me alive if I can no longer chew or swallow on my own or with someone helping me.

Place your initials by either “yes” or “no”:

I want to have food and water provided through a tube or an IV if I am permanently unconscious.
____ Yes_____No

Other Directions: Please list any other things you want **done** or **not done**.

In addition to the directions I have listed on this form, I also want the following:

____

____

____

____

If you do not have other directions, place your initials here:

____ No, I do not have any other directions.

Section 2. If I need someone to speak for me.

This form can be used in the State of Alabama to name a person you would like to make medical or other decisions for you if you become too sick to speak for yourself. This person is called a health care proxy. You do not have to name a health care proxy. The directions in this form will be followed even if you do not name a health care proxy.

Place your initials by only one answer:

_____ I **do not** want to name a health care proxy. (If you check this answer, go to Section 3)

_____ I **do** want the person listed below to be my health care proxy. I have talked with this person about my wishes. I want him/her to make health care decisions for me in non-terminal situations in which I am unable to make or communicate decisions for myself, as well as those in which I am terminally ill or prematurely unconscious. Even though my Proxy may only make decisions for me when I am not able to do so, I specifically intend for him/her to have immediate access to my protected health information and I designate him/her as my "personal representative" as defined by 45 CFR §164-502 (HIPAA), and authorize him/her to have the same access to my protected health information as I would myself, including but not limited to viewing records, requesting and obtaining copies thereof, and executing releases as may be required. I further authorize and direct covered entities to provide my Proxy/Health Care Agent/Personal Representative with the same access to my protected health information as I would have myself. I intend this authority to remain in full force and effect until my death unless earlier revoked by me. This Power of Attorney shall not be affected by my disability, incompetency, or incapacity and grants to my proxy the authority to make health care decisions for me as defined in Section 26-1-2 of the Code of Alabama 1975.

First choice for proxy: ____

Relationship to me: ____

Address:____

City:_____________________________State________Zip ____________

Day-time phone number: ____

Night-time phone number: _______________________________________

If this person is not able, not willing, or not available to be my health care proxy, this is my next choice:

Second choice for proxy: ____

Relationship to me: ____

Address:____

City:_____________________________State________Zip ____________

Day-time phone number: ____

Night-time phone number: _______________________________________

Instructions for Proxy

Place your initials by either "yes" or "no":

I want my health care proxy to make decisions about whether to give me food and water through a tube or an IV. ______Yes______No

Place your initials by only one of the following:

____ I want my health care proxy to follow only the directions as listed on this form.

_____ I want my health care proxy to follow my directions as listed on this form and to make any decisions about things I have not covered in the form.

_____ I want my health care proxy to make the final decision, even though it could mean doing something different from what I have listed on this form.

Section 3. The things listed on this form are what I want.

I understand the following:

- If my doctor or hospital does not want to follow the directions I have listed, they must see that I get to a doctor or hospital who will follow my directions.

- If I am pregnant, or if I become pregnant, the choices I have made on this form will not be followed until after the birth of the baby.

- If the time comes for me to stop receiving life sustaining treatment or food and water through a tube or an IV, I direct that my doctor talk about the good and bad points of doing this, along with my wishes, with my health care proxy, if I have one, and with the following people:

____

____

Section 4. My signature

Your name: ____

The month, day, and year of your birth: ______________________________

Your signature: ____

Date signed: ____

Section 5. Witnesses (need two witnesses to sign)

I am witnessing this form because I believe this person to be of sound mind. I did not sign the person's signature, and I am not the health care proxy. I am not related to the person by blood, adoption, or marriage and not entitled to any part of his or her estate. I am at least 19 years of age and am not directly responsible for paying for his or her medical care.

Name of first witness: ______________________________________

Signature: ____

Date: ____

Name of second witness: ____________________________________

Signature: ____

Date: ____

Section 6. Signature of Proxy

I,____, am willing to serve as the health care proxy.

Signature:____Date: ___________________________

Signature of Second Choice for Proxy:

I,____________________________, am willing to serve as the health care proxy if the first

choice cannot serve. Signature: ____

Date: __________________________