I. HEALTH CARE POWER OF ATTORNEY AND II. HEALTH CARE TREATMENT INSTRUCTIONS IN THE EVENT OF END-STAGE MEDICAL CONDITION OR PERMANENT UNCONSCIOUSNESS ("LIVING WILL")

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 care decision as determined by my doctor or whenever I personally inform my doctor. My agent may not delegate the authority to make decisions.

APPOINTMENT OF HEALTH CARE AGENT:

I appoint the following health care agent: *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.*

Health Care Agent: _____
(Name and Relationship)

Address: Telephone Numbers

_____ _____ Home

_____ _____ Work

E-Mail: _____ _____ Cell

If my health care agent is not reasonably available, or is unable or unwilling to act in a timely manner, 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. (It is helpful, but not required, to name alternative health care agents).

1ST ALTERNATE

Name and Relationship

Address

City State Zip

Home Phone Cell Phone

Work Phone E-Mail

2ND ALTERNATE

Name and Relationship

Address

City State Zip

Home Phone Cell Phone

Work Phone E-Mail

SEPARATE HIPAA AUTHORIZATION EFFECTIVE IMMEDIATELY

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 HIPAA 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 these privacy rules.

HEALTH CARE AGENT POWERS

My health care agent has all of the following powers subject to the health care treatment instructions that follow in PART II (cross out 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 obtain 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 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) or other order effectuating my wishes and to sign any required documents and consents.
6. To carry out my wishes regarding funeral, burial, and the disposition of my body.
7. To take any legal action necessary to do what I have directed.

The foregoing powers shall apply with respect to both physical and mental health care as defined under Section 5422 of the Probate, Estates and Fiduciaries Code. I do not have a mental health care power of attorney or declaration under Chapter 58 of the Probate, Estates and Fiduciaries Code. (Modify or use a different form as needed if you have a mental health care power of attorney or declaration)

I nominate my health care agent as the guardian of my person, should such a guardian be necessary.

GUIDANCE FOR HEALTH CARE AGENT (OPTIONAL) Goals (Leave Blank if Goals Adequately Expressed in the Rest of this Document):

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 life for as long as possible, preservation of mental function, care at home, etc.):

_____

_____

_____

Severe Brain Damage or Brain Disease:

If I should suffer from severe and irreversible brain damage or brain disease which has made me unable to recognize or interact with other people and from which my doctors believe there is no realistic hope of significant recovery, I would consider such a condition unacceptable and the application of aggressive medical care to extend my life in this condition to be burdensome. I therefore request that my health care agent respond to any 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. Keep me comfortable and allow natural death to occur.

Initials _____ I disagree. Use all medical treatment that is needed to keep me alive.

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. These instructions are intended 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 in an irreversible coma or an irreversible vegetative state, and there is no realistic hope of significant recovery, then I choose the following (indicate your choice by initialing your preference):

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

1. 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. Medical or surgical treatment to relieve pain or provide comfort may be given even though I do not want it as a life prolonging procedure.
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.

Initials _____ **I do want aggressive medical care**, and give the following instructions.

I wish to receive all medical and surgical treatment needed to keep me alive as long as possible, even though my doctor believes that it will only delay the time of my death or maintain me in a state of permanent unconsciousness. In addition, I direct that I be given health care treatment to relieve pain or provide comfort provided that it does not hasten my death.

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.

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 one option only).

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 one option only.)

_____ I **do consent** to donate my organs and tissues at the time of my death for the purpose of **transplant, medical study or education.** If life prolonging measures are required for a short period in order to carry out my transplant wishes, I want my health care agent to decide how to best carry out my wishes. (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.

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.

Witnesses

_____ _____
Name

_____ _____
Address

_____

_____
Date of Birth

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.)

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 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.

_____ _____
My commission expires Notary Public

APPROVED BY: **Allegheny County Bar Association** ALLEGHENY COUNTY MEDICAL SOCIETY

ADVANCE HEALTH CARE DIRECTIVE NOTIFICATION

Name: _____

I have a Health Care Power of Attorney and a Living Will, and I have talked with my family and my doctor about the care I want. If I am unable to speak for myself, please contact:

_____	_____
Agent	Best Telephone No.
_____	_____
1st Alternate	Best Telephone No.
_____	_____
2nd Alternate	Best Telephone No.

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

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ALLEGHENY COUNTY MEDICAL SOCIETY

My Physician	Telephone
My Attorney	Telephone

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

SAVE

APPROVED BY: **Allegheny County Bar Association**

ALLEGHENY COUNTY MEDICAL SOCIETY