Georgia Advance Health Care Directive

On this date of _____ , I, _____ , do hereby sign, execute, and adopt the following as my Advance Health Care Directive. I direct any and all persons or entities involved with my health care in any manner that these decisions are my wishes and were adopted without duress or force and of my own free will.

I have placed my initials next to the sections of this Directive that I have adopted:

[ ] Living Will
[ ] Selection of Health Care Agent (Durable Power of Attorney for Health Care)
[ ] Designation of Primary Physician
[ ] Organ Donation

Living Will

I, being of sound mind, willfully and voluntarily make known my desire that my life shall not be prolonged under the circumstances set forth below and do declare that if at any time I should **(Initial each option desired)**:

[ ] have a terminal condition,
[ ] be in a coma with no reasonable expectation of regaining consciousness, **OR**
[ ] be in a persistent vegetative state with no reasonable expectation of regaining significant cognitive function, as defined in and established in accordance with the procedures set forth in paragraphs (2), (9), and (13) of Code Section 31-32-2 of the Official Code of Georgia Annotated,

Then, I direct that the application of life-sustaining procedures to my body **(Initial one option):**

[ ] including nourishment and hydration
[ ] including nourishment, but not hydration
[ ] excluding nourishment and hydration

be withheld or withdrawn and that I be permitted to die.

In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this living will shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal. I understand that I may revoke this living will at any time. I understand the full import of this living will, and I am at least 18 years of age and am emotionally and mentally competent to make this living will.

If I am a female and I have been diagnosed as pregnant, this living will shall have no force and effect unless the fetus is not viable and I indicate by initialing after this sentence that I want this living will to be carried out. **(Initial if desired):** [ ]

Other directions **(insert any other instructions):**

Selection of Health Care Agent
(Durable Power of Attorney for Health Care)

Notice: the purpose of this power of attorney is to give the person you designate (your agent) broad powers to make health care decisions for you, including power to require, consent to, or withdraw any type of personal care or medical treatment for any physical or mental condition and to admit you to or discharge you from any hospital, home, or other institution; but not including psychosurgery, sterilization, or involuntary hospitalization or treatment covered by title 37 of the official Code of Georgia Annotated. This form does not impose a duty on your agent to exercise granted powers; but, when a power is exercised, your agent will have to use due care to act for your benefit and in accordance with this form. A court can take away the powers of your agent if it finds the agent is not acting properly. You may name co-agents and successor agents under this form, but you may not name a health care provider who may be directly or indirectly involved in rendering health care to you under this power. Unless you expressly limit the duration of this power in the manner provided below or until you revoke this power or a court acting on your behalf terminates it, your agent may exercise the powers given in this power throughout your lifetime, even after you become disabled, incapacitated, or incompetent. The powers you give your agent, your right to revoke those powers, and the penalties for violating the law are explained more fully in code sections 31-36-6, 31-36-9, And 31-36-10 of the Georgia 'Durable Power of Attorney for Health Care Act' of which this form is a part. That act expressly permits the use of any different form of power of attorney you may desire. If there is anything about this form that you do not understand, you should ask a lawyer to explain it to you.

I hereby appoint _____ (name), of _____ (address), as my attorney-in-fact (my agent) to act for me and in my name in any way I could act in person to make any and all decisions for me concerning my personal care, medical treatment, hospitalization, and health care and to require, withhold, or withdraw any type of medical treatment or procedure, even though my death may ensue. My agent shall have the same access to my medical records that I have, including the right to disclose the contents to others. My agent shall also have full power to make a disposition of any part or all of my body for medical purposes, authorize an autopsy of my body, and direct the disposition of my remains.

The above grant of power is intended to be as broad as possible so that your agent will have authority to make any decision you could make to obtain or terminate any type of health care, including withdrawal of nourishment and fluids and other life-sustaining or death-delaying measures, if your agent believes such action would be consistent with your intent and desires. If you wish to limit the scope of your agent's powers or prescribe special rules to limit the power to make an anatomical gift, authorize autopsy, or dispose of remains, you may do so in the following paragraphs.

The powers granted above shall not include the following powers or shall be subject to the following rules or limitations **(here you may include any specific limitations you deem appropriate, such as your own definition of when life-sustaining or death-delaying measures should be withheld; a direction to continue nourishment and fluids or other life-sustaining or death-delaying treatment in all events; or instructions to refuse any specific types of treatment that are inconsistent with your religious beliefs or unacceptable to you for any other reason, such as blood transfusion, electroconvulsive therapy, or amputation)**:

The subject of life-sustaining or death-delaying treatment is of particular importance. For your convenience in dealing with that subject, some general statements concerning the withholding or removal of life-sustaining or death-delaying treatment are set forth below. **(If you agree with one of these statements, you may initial that statement, but do not initial more than one)**:

[ ] I do NOT want my life to be prolonged nor do I want life-sustaining or death-delaying treatment to be provided or continued if my agent believes the burdens of the treatment outweigh the expected benefits. I want my agent to consider the relief of suffering, the expense involved, and the quality as well as the possible extension of my life in making decisions concerning life-sustaining or death-delaying treatment.

[ ] I DO want my life to be prolonged and I want life-sustaining or death-delaying treatment to be provided or continued unless I am in a coma, including a persistent vegetative state, which my attending physician believes to be irreversible, in accordance with reasonable medical standards at the time of reference. If and when I have suffered such an irreversible coma, I want life-sustaining or death-delaying treatment to be withheld or discontinued.

[ ] I DO want my life to be prolonged to the greatest extent possible without regard to my condition, the chances I have for recovery, or the cost of the procedures.

This power of attorney may be amended or revoked by you at any time and in any manner while you are able to do so. In the absence of an amendment or revocation, the authority granted in this power of attorney will become effective at the time this power is signed and will continue until your death and will continue beyond your death if anatomical gift, autopsy, or disposition of remains is authorized, unless a limitation on the beginning date or duration is made by initialing and completing either or both of the following:

[ ] This power of attorney shall become effective on _____
(Insert a future date or event during your lifetime, such as court determination of your disability, incapacity, or incompetency, when you want this power to first take effect).

[ ] This power of attorney shall terminate on_____
(Insert a future date or event during your lifetime, such as court determination of your disability, incapacity, or incompetency, when you want this power to terminate prior to your death).

If you wish to name an alternate agent, insert the names and addresses of such successors in the following paragraph:

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)

If you wish to name a guardian of your person in the event a court decides that one should be appointed, you may, but are not required to, do so by inserting the name of such guardian in the following paragraph. The court will appoint the person nominated by you if the court finds that such appointment will serve your best interests and welfare. You may, but are not required to, nominate as your guardian the same person named in this form as your agent.

If a guardian of my person is to be appointed, I nominate the following to serve as such guardian:
_____ (name of individual you choose as guardian)
_____ (address)

I am fully informed as to all the contents of this form and understand the full import of this grant of powers to my agent.

Designation of Primary Physician

I designate the following physician as my primary physician: _____ (name)
_____ (address)
_____(phone).

OPTIONAL- DESIGNATION OF ALTERNATE PRIMARY PHYSICIAN: 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)
_____ (address)
_____(phone).

Organ Donation

In the event of my death, I have placed my initials next to the following part(s) of my body that I wish donated for the purposes t**hat I have initialed below:**

[ ] any organs or parts **OR**

[ ] eyes	[ ] bone and connective tissue	[ ] skin
[ ] heart	[ ] kidney(s)	[ ] liver
[ ] lung(s)	[ ] pancreas	[ ] other _____

for the purposes of:

[ ] any purpose authorized by law **OR**

[ ] transplantation	[ ] research	[ ] therapy
[ ] medical education	[ ] other limitations _____	

Signature

I sign this Advance Health Care Directive, consisting of the following sections, **which I have initialed below and have elected to adopt:**

[ ] Living Will
[ ] Selection of Health Care Agent (Durable Power of Attorney for Health Care)
[ ] Designation of Primary Physician
[ ] Organ Donation

BY SIGNING HERE I INDICATE THAT I UNDERSTAND THE PURPOSE AND EFFECT OF THIS DOCUMENT.

Signature _____ Date _____

City, County, and State of Residence _____

Notary Acknowledgment

State of _____
County of _____
On _____ , _____ came before me personally and, under oath, stated that he or she is the person described in the above document and he or she signed the above document in my presence. I declare under 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 Public
My commission expires _____

Witness Acknowledgment

The declarant is personally known to me and I believe him or her to be of sound mind and under no duress, fraud, or undue influence. I did not sign the declarant's signature above for or at the direction of the declarant and I am not appointed as the health care agent or attorney-in-fact herein. I am at least eighteen (18) years of age and I am not related to the declarant by blood, adoption, or marriage, entitled to any portion of the estate of the declarant according to the laws of intestate succession or under any will of declarant or codicil thereto, or directly financially responsible for declarant's medical care. I am not a health care provider of the declarant or an employee of the health facility in which the declarant is a patient.

Witness Signature _____ Date _____

Printed Name of Witness _____

Second Witness Signature _____ Date _____

Printed Name of Second Witness _____

An additional witness is required when this document is signed by a patient in a hospital or skilled nursing facility. I hereby witness this living will and attest that I believe the declarant to be of sound mind and to have made this living will willingly and voluntarily.

Additional Witness Signature _____ Date _____

Printed Name of Witness _____
(Medical director of skilled nursing facility or staff physician not participating in care of the patient, or chief of the hospital medical staff, staff physician, or hospital designee not participating in care of the patient.)

Acceptance of Health Care Agent and Attorney-in-Fact for Health Care

I accept my appointment as Health Care Agent and Attorney-in-Fact for Health Care:

Signature _____ Date _____

I accept my appointment as Alternate Health Care Agent and Attorney-in-Fact for Health Care:

Signature _____ Date _____