Idaho 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 (Directive to Withhold or to Provide Treatment)
[ ] Selection of Health Care Agent (Durable Power of Attorney for Health Care)
[ ] Designation of Primary Physician
[ ] Organ Donation

Living Will (Directive to Withhold or to Provide Treatment)

This Directive shall only be effective if I am unable to communicate my instructions and

1.) I have an incurable or irreversible injury, disease, illness or condition, and a medical doctor who has examined me has certified: A. That such injury, disease, illness or condition is terminal; and B. That the application of artificial life-sustaining procedures would serve only to prolong artificially my life; and C. That my death is imminent, whether or not artificial life-sustaining procedures are utilized; **OR**

2.) I have been diagnosed as being in a persistent vegetative state.

In such event, I direct that the following initialed expression of my intent be followed, and that I receive any medical treatment or care that may be required to keep me free of pain or distress.

(Initial one of the following three boxes next to the left-hand margin):

[ ] I direct that all medical treatment, care, nutrition, and hydration necessary to restore my health, sustain my life, and abolish or alleviate pain or distress be provided to me. Nutrition and hydration shall not be withheld or withdrawn from me if I would die from malnutrition or dehydration rather than from my injury, disease, illness, or condition.

[ ] I direct that all medical treatment, care and procedures, including artificial life-sustaining procedures, be withheld or withdrawn, except that nutrition and hydration, whether artificial or non-artificial shall not be withheld or withdrawn from me if, as a result, I would likely die primarily from malnutrition or dehydration rather than from my injury, disease, illness or condition, as follows: *(If none of the following three indented boxes are initialed, then both nutrition and hydration, of any nature, whether artificial or non-artificial, shall be administered.)* **(Initial one of the following three indented boxes if desired)**

[ ] Only hydration of any nature, whether artificial or non-artificial, shall be administered;

[ ] Only nutrition, of any nature, whether artificial or non-artificial, shall be administered;

[ ] Both nutrition and hydration, of any nature, whether artificial or non-artificial shall be administered.

[ ] I direct that all medical treatment, care and procedures be withheld or withdrawn, including withdrawal of the administration of artificial nutrition and hydration.

If I have been diagnosed as pregnant, this Directive shall have no force during the course of my pregnancy. I understand the full importance of this Directive and am mentally competent to make this Directive. No participant in the making of this Directive or in its being carried into effect shall be held responsible in any way for complying with my directions.

PHYSICIAN'S ORDERS FOR SCOPE OF TREATMENT: **Initial one of the following boxes:**

[ ] I have discussed these decisions with my physician and have also completed a Physician Orders for Scope of Treatment (POST) form that contains directions that may be more specific than, but are compatible with, this Directive. I hereby approve of those orders and incorporate them herein as if fully set forth. OR

[ ] I have not completed a Physician Orders for Scope of Treatment (POST) form. If a POST form is later signed by my physician, then this living will shall be deemed modified to be compatible with the terms of the POST form.

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

DESIGNATION OF HEALTH CARE AGENT.: None of the following may be designated as your agent: (1) your treating health care provider; (2) a nonrelative employee of your treating health care provider; (3) an operator of a community care facility; or (4) a nonrelative employee of an operator of a community care facility. If the agent or an alternate agent designated in this Directive is your spouse, and our marriage is thereafter dissolved, such designation shall be thereupon revoked.

I do hereby designate and appoint _____ (name), of _____ (address), as my attorney-in-fact (agent) to make health care decisions for me as authorized in this document. For the purposes of this document, "health care decision" means consent, refusal of consent, or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose, or treat an individual's physical condition.

OPTIONAL - DESIGNATION OF ALTERNATE AGENT: 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)

CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE. By this document I intend to create a durable power of attorney for health care. This power of attorney shall not be affected by my subsequent incapacity. This power shall be effective only when I am unable to communicate rationally.

GENERAL STATEMENT OF AUTHORITY GRANTED. Subject to any limitations in this document, I hereby grant to my agent full power and authority to make health care decisions for me to the same extent that I could make such decisions for myself if I had the capacity to do so. In exercising this authority, my agent shall make health care decisions that are consistent with my desires as stated in this document or otherwise made known to my agent, including, but not limited to, my desires concerning obtaining or refusing or withdrawing artificial life-sustaining care, treatment, services, and procedures including such desires set forth in a living will, Physician Orders for Scope of Treatment (POST) form, or similar document executed by me, if any. **(If you want to limit the authority of your agent to make health care decisions for you, you can state the limitations in next paragraph "Statement of Desires, Special Provisions, and Limitations" below. You can indicate your desires by including a statement of your desires in the same paragraph.)**

STATEMENT OF DESIRES, SPECIAL PROVISIONS, AND LIMITATIONS. **(Your agent must make health care decisions that are consistent with your known desires. You can, but are not required to, state your desires in the space provided below. You should consider whether you want to include a statement of your desires concerning artificial life-sustaining care, treatment, services and procedures. You can also include a statement of your desires concerning other matters relating to your health care, including a list of one or more persons whom you designate to be able to receive medical information about you and/or to be allowed to visit you in a medical institution. You can also make your desires known to your agent by discussing your desires with your agent or by some other means. If there are any types of treatment that you do not want to be used, you should state them in the space below. If you want to limit in any other way the authority given your agent by this Directive, you should state the limits in the space below. If you do not state any limits, your agent will have broad powers to make health care decisions for you, except to the extent that there are limits provided by law.)**

In exercising the authority under this durable power of attorney for health care, my agent shall act consistently with my desires as stated below and is subject to the special provisions and limitations stated in my Physician Orders for Scope of Treatment (POST) form, a living will, or similar document executed by me, if any. **(You may attach additional pages or documents if you need more space to complete your statement.)**

INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY PHYSICAL OR MENTAL HEALTH. Subject to any limitations in this document, my agent has the power and authority to do all of the following: (a) Request, review, and receive any information, verbal or written, regarding my physical or mental health, including, but not limited to, medical and hospital records; (b) Execute on my behalf any releases or other documents that may be required in order to obtain this information; (c) Consent to the disclosure of this information; and (d) Consent to the donation of any of my organs for medical purposes.
(If you want to limit the authority of your agent to receive and disclose information relating to your health, you must state the limitations in "Statement of Desires, Special Provisions, and Limitations" above.)

HIPAA RELEASE AUTHORITY. My agent shall 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. 1320d and 45 CFR 160 through 164. I authorize any physician, health care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy, or other covered health care provider, any insurance company, 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, including all information relating to the diagnosis of HIV/AIDS, sexually transmitted diseases, mental illness, and drug or alcohol abuse. The authority given my agent shall supersede any other agreement that I may have made with my health care providers to restrict access to or disclosure of my individually identifiable health information. 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.

SIGNING DOCUMENTS, WAIVERS, AND RELEASES. Where necessary to implement the health care decisions that my agent is authorized by this document to make, my agent has the power and authority to execute on my behalf all of the following: (a) Documents titled or purporting to be a "Refusal to Permit Treatment" and "Leaving Hospital Against Medical Advice;" and (b) Any necessary waiver or release from liability required by a hospital or physician.

PRIOR DESIGNATIONS REVOKED. I revoke any prior durable power of attorney for health care.

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 **that 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 (Directive to Withhold or to Provide Treatment)
[ ] 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 _____

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 _____