Maryland 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 (Treatment Preferences)
[ ] Selection of Health Care Agent
[ ] Designation of Primary Physician
[ ] Organ Donation

Using this advance directive form to do health care planning is completely optional. Other forms are also valid in Maryland. No matter what form you use, talk to your family and others close to you about your wishes. Part I lets you write your preferences about efforts to extend your life in three situations: terminal condition, persistent vegetative state, and end-stage condition. Part II of this form lets you choose someone to make your health care decisions for you if you cannot make them. The person you pick is called your health care agent. Make sure you talk to your health care agent (and any back-up agents) about this important role. Part III allows you to designate your choice as your primary doctor. In Part IV, you can choose to become an organ donor after your death. You can fill out any or all parts of this form. Use the form to reflect your wishes, then sign in front of two witnesses and a notary public. If your wishes change, make a new advance directive. Make sure you give a copy of the completed form to your health care agent, your doctor, and others who might need it. Keep a copy at home in a place where someone can get it if needed. Review what you have written periodically.

Part I: Living Will (Treatment Preferences)

If I am not able to make an informed decision regarding my health care, I direct my health care providers to follow my instructions as set forth below:

PREFERENCE IN CASE OF TERMINAL CONDITION: **(If you want to state your preference, initial one statement only. If you do not want to state a preference here, cross through the whole section.)**

[ ] Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means.

[ ] Keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means.

[ ] Try to extend my life for as long as possible, using all available interventions that in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical means.

PREFERENCE IN CASE OF PERSISTENT VEGETATIVE STATE: **(If you want to state your preference, initial one statement only. If you do not want to state a preference here, cross through the whole section.)**
If my doctors certify that I am in a persistent vegetative state, that is, if I am not conscious and am not aware of myself or my environment or able to interact with others, and there is no reasonable expectation that I will ever regain consciousness:

[ ] Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means.

[ ] Keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means.

[ ] Try to extend my life for as long as possible, using all available interventions that in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical means.

PREFERENCE IN CASE OF END-STAGE CONDITION: **(If you want to state your preference, initial one statement only. If you do not want to state a preference here, cross through the whole section.)**

If my doctors certify that I am in an end-stage condition, that is, an incurable condition that will continue in its course until death and that has already resulted in loss of capacity and complete physical dependency:

[ ] Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means.

[ ] Keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means.

[ ] Try to extend my life for as long as possible, using all available interventions that in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical means.

PAIN RELIEF: No matter what my condition, give me the medicine or other treatment I need to relieve pain.

IN CASE OF PREGNANCY: (Optional, for women of child-bearing years only): If I am pregnant, my decision concerning life-sustaining procedures shall be modified as follows:

EFFECT OF STATED PREFERENCES: **(Read both of these statements carefully. Then, initial one only.)**

[ ] I realize I cannot foresee everything that might happen after I can no longer decide for myself. My stated preferences are meant to guide whoever is making decisions on my behalf and my health care providers, but I authorize them to be flexible in applying these statements if they feel that doing so would be in my best interest.

[ ] I realize I cannot foresee everything that might happen after I can no longer decide for myself. Still, I want whoever is making decisions on my behalf and my health care providers to follow my stated preferences exactly as written, even if they think that some alternative is better.

OPTIONAL: STATEMENT OF GOALS AND VALUES: I want to say something about my goals and values, and especially what's most important to me during the last part of my life:

Part II: Selection of Health Care Agent

I appoint the following individual as my agent to make health care decisions for me:

_____ (name),
of _____ (address).

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)

POWERS AND RIGHTS OF HEALTH CARE AGENT: I want my agent to have full power to make health care decisions for me, including the power to: 1. Consent or not consent to medical procedures and treatments which my doctors offer, including things that are intended to keep me alive, like ventilators and feeding tubes; 2. Decide who my doctor and other health care providers should be; and 3. Decide where I should be treated, including whether I should be in a hospital, nursing home, other medical care facility, or hospice program. 4. I also want my agent to: a. Ride with me in an ambulance if ever I need to be rushed to the hospital; and b. Be able to visit me if I am in a hospital or any other health care facility.

This advance directive does not make my agent responsible for any of the costs of my care.

This power is subject to the following conditions or limitations:

HOW MY AGENT IS TO DECIDE SPECIFIC ISSUES: I trust my agent's judgment. My agent should look first to see if there is anything in Part II of this advance directive that helps decide the issue. Then, my agent should think about the conversations we have had, my religious or other beliefs and values, my personality, and how I handled medical and other important issues in the past. If what I would decide is still unclear, then my agent is to make decisions for me that my agent believes are in my best interest. In doing so, my agent should consider the benefits, burdens, and risks of the choices presented by my doctors.

OPTIONAL - PEOPLE MY AGENT SHOULD CONSULT: In making important decisions on my behalf, I encourage my agent to consult with the following people. By filling this in, I do not intend to limit the number of people with whom my agent might want to consult or my agent's power to make these decisions.

IN CASE OF PREGNANCY (OPTIONAL, for women of child-bearing years only)
If I am pregnant, my agent shall follow these specific instructions:

ACCESS TO MY HEALTH INFORMATION - Federal Privacy Law (HIPAA) Authorization
If, prior to the time the person selected as my agent has power to act under this document, my doctor wants to discuss with that person my capacity to make my own health care decisions, I authorize my doctor to disclose protected health information which relates to that issue. Once my agent has full power to act under this document, my agent may request, receive, and review any information, oral or written, regarding my physical or mental health, including, but not limited to, medical and hospital records and other protected health information, and consent to disclosure of this information. For all purposes related to this document, my agent is my personal representative under the Health Insurance Portability and Accountability Act (HIPAA). My agent may sign, as my personal representative, any release forms or other HIPAA-related materials.

EFFECTIVENESS OF THIS PART: My agent's power is in effect: **(Initial your choice)**

[ ] Immediately after I sign this document, subject to my right to make any decision about my health care if I want and am able to. **OR**

[ ] Whenever I am not able to make informed decisions about my health care, either because the doctor in charge of my care (attending physician) decides that I have lost this ability temporarily, or my attending physician and a consulting doctor agree that I have lost this ability permanently.

Part III: 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).

Part IV: 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 (Treatment Preferences)
[ ] Selection of Health Care Agent
[ ] 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

I accept my appointment as Health Care Agent:

Signature _____ Date _____

I accept my appointment as Alternate Health Care Agent:

Signature _____ Date _____