Minnesota 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 (Health Care Living Will)
[ ] Selection of Health Care Agent (Proxy Designation)
[ ] Designation of Primary Physician
[ ] Organ Donation

Notice: This is an important legal document. Before signing this document, you should know these important facts:

(a) This document gives your health care providers or your designated proxy the power and guidance to make health care decisions according to your wishes when you are in a terminal condition and cannot do so. This document may include what kind of treatment you want or do not want and under what circumstances you want these decisions to be made. You may state where you want or do not want to receive any treatment.

(b) If you name a proxy in this document and that person agrees to serve as your proxy, that person has a duty to act consistently with your wishes. If the proxy does not know your wishes, the proxy has the duty to act in your best interests. If you do not name a proxy, your health care providers have a duty to act consistently with your instructions or tell you that they are unwilling to do so.

(c) This document will remain valid and in effect until and unless you amend or revoke it. Review this document periodically to make sure it continues to reflect your preferences. You may amend or revoke the living will at any time by notifying your health care providers.

d) Your named proxy has the same right as you have to examine your medical records and to consent to their disclosure for purposes related to your health care or insurance unless you limit this right in this document.

(e) If there is anything in this document that you do not understand, you should ask for professional help to have it explained to you.

Living Will (Health Care Living Will)

TO MY FAMILY, DOCTORS, AND ALL THOSE CONCERNED WITH MY CARE:

I, being an adult of sound mind, willfully and voluntarily make this statement as a directive to be followed if I am in a terminal condition and become unable to participate in decisions regarding my health care. I understand that my health care providers are legally bound to act consistently with my wishes, within the limits of reasonable medical practice and other applicable law. I also understand that I have the right to make medical and health care decisions for myself as long as I am able to do so and to revoke this living will at any time.

The following are my feelings and wishes regarding my health care **(You may state the circumstances under which this living will applies):**

I particularly DO want to have all appropriate health care that will help in the following ways **(You may give instructions for care you do want):**

I particularly do NOT want the following **(You may list specific treatment you do not want in certain circumstances):**

I particularly DO want to have the following kinds of life-sustaining treatment if I am diagnosed to have a terminal condition **(You may list the specific types of life-sustaining treatment that you do want if you have a terminal condition):**

I particularly do NOT want the following kinds of life-sustaining treatment if I am diagnosed to have a terminal condition **(You may list the specific types of life-sustaining treatment that you do not want if you have a terminal condition):**

I recognize that if I reject artificially-administered sustenance, then I may die of dehydration or malnutrition rather than from my illness or injury. The following are my feelings and wishes regarding artificially-administered sustenance should I have a terminal condition **(You may indicate whether you wish to receive food and fluids given to you in some other way than by mouth if you have a terminal condition):**

Thoughts I feel are relevant to my instructions **(You may, but need not, give your religious beliefs, philosophy, or other personal values that you feel are important. You may also state preferences concerning the location of your care):**

Selection of Health Care Agent (Proxy Designation)

(If you wish, you may name someone to see that your wishes are carried out, but you do not have to do this. You may also name a proxy without including specific instructions regarding your care. If you name a proxy, you should discuss your wishes with that person.)

If I become unable to communicate my instructions, I designate the following person(s) to act on my behalf consistently with my instructions, if any, as stated in this document.

_____ (name)
_____ (address)

OPTIONAL - DESIGNATION OF ALTERNATE PROXY: If I revoke my proxy's authority or if my proxy is not willing, able, or reasonably available to make a health care decision for me, I designate as my alternate proxy

_____ (name of individual you choose as alternate proxy)
_____ (address)

Unless I write instructions that limit my proxy's authority, my proxy has full power and authority to make health care decisions for me. If a guardian is to be appointed for me, I nominate my proxy (or alternate proxy, if then serving) named in this document to act as my guardian.

I understand that I have the right to revoke the appointment of the persons named above to act on my behalf at any time by communicating that decision to the proxy or my health care provider.

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 (Health Care Living Will)
[ ] Selection of Health Care Agent (Proxy Designation)
[ ] 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 proxy 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 Proxy

I accept my appointment as Health Care Agent and Proxy:

Signature _____ Date _____

I accept my appointment as Alternate Health Care Agent and Proxy:

Signature _____ Date _____