Mississippi 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 (Instructions for Health Care)
[ ] Selection of Health Care Agent (Power of Attorney for Health Care)
[ ] Designation of Primary Physician
[ ] Organ Donation

You have the right to give instructions about your own health care. You also have the right to name someone else to make health care decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding the designation of your primary physician and make an organ donation. If you use this form, you may complete or modify all or any part of it. You are free to use a different form.

PART 1 of this form lets you give specific instructions about any aspect of your health care. Choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive, including the provision of artificial nutrition and hydration, as well as the provision of pain relief. Space is provided for you to add to the choices you have made or for you to write out any additional wishes.

PART 2 of this form is a Power of Attorney for Health Care. Part 2 lets you name another individual as agent to make health care decisions for you if you become incapable of making your own decisions or if you want someone else to make those decisions for you now even though you are still capable. Unless related to you, your agent may not be an owner, operator, or employee of a residential long-term health care institution at which you are receiving care. Unless the form you sign limits the authority of your agent, your agent may make all health care decisions for you. This form has a place for you to limit the authority of your agent. You need not limit the authority of your agent if you wish to rely on your agent for all health care decisions that may have to be made. If you choose not to limit the authority of your agent, your agent will have the right to: (1) Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition, (2) Select or discharge health care providers and institutions, (3) Approve or disapprove diagnostic tests, surgical procedures, programs of medication, and orders not to resuscitate, and (4) Direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care.

PART 3 of this form lets you designate a physician to have primary responsibility for your health care.

PART 4 of this form allows you to specify your desires concerning organ donation after death.

After completing this form, sign and date the form at the end in front of two (2) witnesses and a notary public. Give a copy of the signed and completed form to your physician, any other health care providers you may have, any health care institution at which you are receiving care, and any health care agents you have named. You should talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take the responsibility. You have the right to revoke this advance health care directive or replace this form at any time.

Part 1: Living Will (Instructions for Health Care)

If you are satisfied to allow your agent to determine what is best for you in making end-of-life decisions, you need not fill out this part of the form. If you do fill out this part of the form, you may strike any wording you do not want.

END-OF-LIFE DECISIONS: I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice **I have initialed below**:

[ ] **Choice NOT To Prolong Life**: I do NOT want my life to be prolonged if:
(a) I have an incurable and irreversible condition that will result in my death within a relatively short time;
(b) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness; **OR**
(c) the likely risks and burdens of treatment would outweigh the expected benefits.

OR

[ ] **Choice TO Prolong Life**: I DO want my life to be prolonged as long as possible within the limits of generally-accepted health care standards.

ARTIFICIAL NUTRITION AND HYDRATION: Artificial nutrition and hydration must be provided, withheld, or withdrawn in accordance with the choice I have made above **unless I initial the following box:**
If I initial this box[ ], artificial nutrition and hydration must be provided regardless of my condition and regardless of the choice I have made above.

RELIEF FROM PAIN: Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death **(list exceptions)**:

OTHER WISHES: **(If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that (add additional sheets if needed):**

Part 2: Selection of Health Care Agent (Power of Attorney for Health Care)

DESIGNATION OF AGENT: I designate 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 alternate agent

_____ (name of individual you choose as alternate agent)

_____ (address)

AGENT'S AUTHORITY: My agent is authorized to make all health care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration, and all other forms of health care to keep me alive, except as I state here **(add additional sheets if needed):**

WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions **unless I mark the following box:**

If I initial this box[ ], my agent's authority to make health care decisions for me takes effect immediately.

AGENT'S OBLIGATION: My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 1 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

NOMINATION OF GUARDIAN: If a guardian of my person needs to be appointed for me by a court, I nominate the agent (or alternate agent if then serving) designated in this form.

Part 3: 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 4: 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 (Instructions for Health Care)
[ ] Selection of Health Care Agent (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

WITNESS #1
I declare under penalty of perjury pursuant to Section 97-9-61, Mississippi Code of 1972, that the principal is personally known to me, that the principal signed or acknowledged this power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, that I am not the person appointed as agent by this document, and that I am not a health care provider, or an employee of a health care provider or facility. I am at least eighteen (18) years of age and I am not related to the principal by blood, marriage, or adoption, and to the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

Witness #1 Signature _____ Date _____

Printed Name of Witness _____

WITNESS #2
I declare under penalty of perjury pursuant to Section 97-9-61, Mississippi Code of 1972, that the principal is personally known to me, that the principal signed or acknowledged this power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, that I am not the person appointed as agent by this document, and that I am at least eighteen (18) years of age and I am not a health care provider, or an employee of a health care provider or facility.

Witness #2 Signature _____ Date _____

Printed Name of Witness _____

Acceptance of Health Care Agent and Attorney-n-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 _____