North Carolina 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 (Declaration of Desire for a Natural Death)
[ ] Selection of Health Care Agent (Health Care Power of Attorney)
[ ] Designation of Primary Physician
[ ] Organ Donation

Living Will (Declaration of Desire for a Natural Death)

I, being of sound mind, desire that, as specified below, my life not be prolonged by extraordinary means or by artificial nutrition or hydration if my condition is determined to be terminal and incurable or if I am diagnosed as being in a persistent vegetative state. I am aware and understand that this writing authorizes a physician to withhold or discontinue extraordinary means or artificial nutrition or hydration, in accordance with my specifications set forth below **(initial any of the following, as desired):**

[ ] If my condition is determined to be terminal and incurable, I authorize the following:
  [ ] My physician may withhold or discontinue extraordinary means only.
  [ ] In addition to withholding or discontinuing extraordinary means if such means are necessary, my physician may withhold or discontinue either artificial nutrition or hydration, or both.
[ ] If my physician determines that I am in a persistent vegetative state, I authorize the following:
  [ ] My physician may withhold or discontinue extraordinary means only.
  [ ] In addition to withholding or discontinuing extraordinary means if such means are necessary, my physician may withhold or discontinue either artificial nutrition or hydration, or both.

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

NOTICE: This document gives the person you designate as your health care agent broad powers to make health care decisions, including mental health treatment decisions for you. Except to the extent that you express specific limitations or restrictions on the authority of your health care agent, this power includes the power to consent to your doctor not giving treatment or stopping treatment necessary to keep you alive, admit you to a facility, and administer certain treatments and medications. This power exists only as to those health care decisions for which you are unable to give informed consent. This form does not impose a duty on your health care agent to exercise granted powers, but when a power is exercised,

your health care agent will have to use due care to act in your best interests and in accordance with this document. For mental health treatment decisions, your health care agent will act according to how the health agent believes you would act if you were making the decision. This health care power of attorney may be revoked by you at any time in any manner by which you are able to communicate your intent to revoke to your health care agent and your attending physician. Because the powers granted by this document are broad and sweeping, you should discuss your wishes concerning life-sustaining procedures, mental health treatment, and other health care decisions with your health care agent. Use of this form in the creation of a health care power of attorney is lawful and is authorized pursuant to North Carolina law. However, use of this form is an optional and non-exclusive method for creating a health care power of attorney and North Carolina law does not bar the use of any other or different form of power of attorney for health care that meets the statutory requirements.

DESIGNATION OF AGENT: I, being of sound mind, hereby appoint:
____ (name),
of ____ (address),
as my health care attorney-in-fact (herein referred to as my "health care agent") to act for me and in my name (in any way I could act in person) to make health care decisions for me as authorized in this document.

OPTIONAL - DESIGNATION OF ALTERNATE HEALTH CARE AGENT: If I revoke my health care agent's authority or if my health care agent is not willing, able, or reasonably available to make a health care decision for me, I designate as my alternate health care agent
____________________________ (name of individual you choose as alternate health care agent)
____ (address)

EFFECTIVENESS OF APPOINTMENT: Unless revoked, the authority granted in this document shall become effective when and if the physician or physicians designated as my primary physicians in this document determine that I lack sufficient understanding or capacity to make or communicate decisions relating to my health care and will continue in effect during my incapacity, until my death.

For decisions related to mental health treatment, this determination shall be made by the following physician or eligible psychologist **(include here a designation of your choice):**

____ (name),
of ____(address)

GENERAL STATEMENT OF AUTHORITY GRANTED: Except as indicated below, I hereby grant to my health care agent named above full power and authority to make health care decisions, including mental health treatment decisions, on my behalf, including, but not limited to, the following **:**

(1) To request, review, and receive any information, verbal or written, regarding my physical or mental health, including, but not limited to medical and hospital records, and to consent to the disclosure of this information,
(2) To employ or discharge my health care providers,
(3) To consent to and authorize my admission to and discharge from a hospital, nursing or convalescent home, or other institution,
(4) To consent to and authorize my admission to and retention in a facility for the care or treatment of mental illness,
(5) To consent to and authorize the administration of medications for mental health treatment and electroconvulsive treatment (ECT), commonly referred to as "shock treatment,"
(6) To give consent for, withdraw consent for, or withhold consent for x-ray, anesthesia, medication, surgery, and all other diagnostic and treatment procedures ordered by or under the authorization of a licensed physician, dentist, or podiatrist. This authorization specifically includes the power to consent to measures for relief of pain,
(7) To authorize the withholding or withdrawal of life-sustaining procedures when and if my physician determines that I am terminally ill, am permanently in a coma, suffer severe dementia, or am in a persistent vegetative state. **Life-sustaining procedures are those forms of medical care that only serve to artificially prolong the dying process and may include mechanical ventilation, dialysis, antibiotics, artificial nutrition and hydration, and other forms of medical treatment which sustain, restore, or supplant vital bodily functions. Life-sustaining procedures do not include care necessary to provide comfort or alleviate pain.**

I DESIRE THAT MY LIFE NOT BE PROLONGED BY LIFE-SUSTAINING PROCEDURES IF I AM TERMINALLY ILL, AM PERMANENTLY IN A COMA, SUFFER SEVERE DEMENTIA, OR AM IN A PERSISTENT VEGETATIVE STATE.

(8) To exercise any right I may have to make a disposition of any part or all of my body for medical purposes, donate my organs, authorize an autopsy, and direct the disposition of my remains,
(9) To take any lawful actions that may be necessary to carry out these decisions, including the granting of releases of liability to medical providers.

NOTICE: The above grant of power is intended to be as broad as possible so that your health care agent will have authority to make any decisions you could make to obtain or terminate any type of health care. If you wish to limit the scope of your health care agent's powers, you may do so in this section.

SPECIAL PROVISIONS AND LIMITATIONS: In exercising the authority to make health care decisions on my behalf, the authority of my health care agent is subject to the following special provisions and limitations **(here you may include any specific limitations you deem appropriate such as: your own definition of when life-sustaining treatment should be withheld or discontinued, or instructions to refuse any specific types of treatment that are inconsistent with your religious beliefs or unacceptable to you for any other reason. Attach additional pages if needed):**

In exercising the authority to make mental health decisions on my behalf, the authority of my health care agent is subject to the following special provisions and limitations **(here you may include any specific limitations you deem appropriate such as: limiting the grant of authority to make only mental health treatment decisions, your own instructions regarding the administration or withholding of psychotropic medications and electroconvulsive treatment (ECT), instructions regarding your admission to and retention in a health care facility for mental health treatment, or instructions to refuse any specific types of treatment that are unacceptable to you. Attach additional pages as needed)**:

NOTICE: This health care power of attorney may incorporate or be combined with an advance instruction for mental health treatment, executed in accordance with Part 2 of Article 3 of Chapter 122C of the North Carolina General Statutes, which you may use to state your instructions regarding mental health treatment in the event you lack sufficient understanding or capacity to make or communicate mental health treatment decisions. Because your health care agent's decisions must be consistent with any statements you have expressed in an advance instruction, you should indicate here whether you have executed an advance instruction for mental health treatment (indicate your actions and attach additional pages if needed):

In exercising the authority to make decisions regarding autopsy, anatomical gifts and disposition of remains on my behalf, the authority of my health care agent is subject to the following special provisions and limitations. **(Here you may include any specific limitations you deem appropriate such as: limiting the grant of authority and the scope of authority, instructions regarding gifts of the body or body part, or instructions regarding burial or cremation):**

GUARDIANSHIP PROVISION: If it becomes necessary for a court to appoint a guardian of my person, I nominate my health care agent acting under this document to be the guardian of my person and to serve without bond or security. The guardian shall act consistently with N.C.G.S. 35A-1201(a)(5).

RELIANCE OF THIRD PARTIES ON HEALTH CARE AGENT: No person who relies in good faith upon the authority of or any representations by my health care agent shall be liable to me or my estate, heirs, successors, assigns, or personal representatives, for actions or omissions by my health care agent. The powers conferred on my health care agent by this document may be exercised by my health care agent alone, and my health care agent's signature or act under the authority granted in this document may be accepted by persons as fully authorized by me and with the same force and effect as if I were personally present, competent, and acting on my own behalf. All acts performed in good faith by my health care agent pursuant to this power of attorney are done with my consent and shall have the same validity and effect as if I were present and exercised the powers myself, and shall inure to the benefit of and bind me or my estate, heirs, successors, assigns, and personal representatives. The authority of my health care agent pursuant to this power of attorney shall be superior to and binding upon my family, relatives, friends, and others.

MISCELLANEOUS PROVISIONS: I revoke any prior health care power of attorney. My health care agent shall be entitled to sign, execute, deliver, and acknowledge any contract or other document that may be necessary, desirable, convenient, or proper in order to exercise and carry out any of the powers described in this document and incur reasonable costs on my behalf, incident to the exercise of these powers; provided, however, that except as shall be necessary in order to exercise the powers described in this document relating to my health care, my health care agent shall not have any authority over my property or financial affairs. My health care agent and his or her estate, heirs, successors, and assigns are hereby released and forever discharged by me or my estate, heirs, successors, assigns, and personal representatives from all liability and claims or demands of all kinds arising out of the acts or omissions of my health care agent pursuant to this document, except for willful misconduct or gross negligence. No act or omission of my health care agent, any other person, institution, or facility acting in good faith in reliance on the authority of my health care agent pursuant to this health care power of attorney shall be considered suicide, nor the cause of my death for any civil or criminal purposes, nor shall it be considered unprofessional conduct or as lack of professional competence. Any person, institution, or facility against whom criminal or civil liability is asserted because of conduct authorized by this health care power of attorney may interpose this document as a defense.

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 of Declarant/Principal

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

[ ] Living Will (Declaration of Desire for a Natural Death)
[ ] Selection of Health Care Agent (Health Care Power of Attorney)
[ ] Designation of Primary Physician
[ ] Organ Donation

BY SIGNING HERE I INDICATE THAT I AM MENTALLY ALERT AND COMPETENT, FULLY INFORMED AS TO THE CONTENTS OF THIS DOCUMENT, AND UNDERSTAND THE FULL IMPORT AND THE PURPOSE AND EFFECT OF THIS DOCUMENT.

Signature _______________________________ Date ____________________

City, County, and State of Residence ____

Notary or Superior Court Clerk Certification

State of ____________________
County of ____________________

I, ____________________, Clerk (Assistant Clerk) of Superior Court or Notary Public (circle one as appropriate) for _______________ County hereby certify that ______________________, the declarant/principal, appeared before me and swore to me and to the witnesses in my presence that this instrument is his Advance Health Care Directive, consisting of a Declaration Of A Desire For A Natural Death, a Health Care Power of Attorney, a Designation of Primary Physician, and an Organ Donation, and that he had willingly and voluntarily made and executed it as his free act and deed for the purposes expressed in it.

I further certify that _____________________________ and __________________________, witnesses, appeared before me and swore that they witnessed __________________________, the declarant/principal, sign the attached Advance Health Care Directive, consisting of a Declaration of a Desire for a Natural Death, a Health Care Power of Attorney, a Designation of Primary Physician, and an Organ Donation, believing him to be of sound mind; and also swore that at the time they witnessed the Advance Health Care Directive, consisting of a Declaration of a Desire for a Natural Death, a Health Care Power of Attorney, a Designation of Primary Physician, and an Organ Donation, (i) they were not related within the third degree to the declarant/principal or to the declarant/principal's spouse, and (ii) they did not know or have a reasonable expectation that they would be entitled to any portion of the estate of the declarant/principal upon the declarant/principal's death under any will of the declarant/principal or codicil thereto then existing or under the Intestate Succession Act as it provides at that time, and (iii) they were not a physician attending the declarant/principal or an employee of an attending physician or an employee of a health facility in which the declarant/principal was a patient or an employee of a nursing home or any group-care home in which the declarant/principal resided, and (iv) they did not have a claim against the declarant/principal. I further certify that I am satisfied as to the genuineness and due execution of the Advance Health Care Directive, consisting of a Declaration of a Desire for a Natural Death, a Health Care Power of Attorney, a Designation of Primary Physician, and an Organ Donation.

This the ____ day of ______, ____.

Clerk (Assistant Clerk) of Superior Court or Notary Public (circle one as appropriate) for the County of ___________"

____
Official Signature
My commission expires ____________________

Witness Acknowledgment

I hereby state that the declarant/principal, being of sound mind signed the above Advance Health Care Directive, consisting of a Declaration of a Desire for a Natural Death, a Health Care Power of Attorney, a Designation of Primary Physician, and an Organ Donation, in my presence and that I am not related to the declarant/principal by blood or marriage and that I do not know or have a reasonable expectation that I would be entitled to any portion of the estate of the declarant/principal under any existing will or codicil of the declarant/principal or as an heir under the Intestate Succession Act if the declarant/principal died on this date without a will. I also state that I am not the declarant/principal's attending physician or an employee of the declarant/principal's attending physician, or an employee of a health facility in which the declarant/principal is a patient or an employee of a nursing home or any group-care home where the declarant/principal resides. I further state that I do not now have any claim against the declarant/principal.

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 ____________________

NOTE: A copy of this document should be given to your health care agent and alternate health care agent (if an alternate has been designated), and to your primary physician (and to your alternate primary physician if one has been designated), and to family members.