Rhode Island 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)
[ ] Selection of Health Care Agent (Durable Power of Attorney for Health Care)
[ ] Designation of Primary Physician
[ ] Organ Donation

Living Will (Declaration)

I, being of sound mind, willfully and voluntarily make known my desire that my dying shall not be artificially-prolonged under the circumstances set forth below, and do hereby declare:

If I should have an incurable or irreversible condition that will cause my death, and if I am unable to make decisions regarding my medical treatment, I direct my attending physician to withhold or withdraw procedures that merely prolong the dying process and are not necessary to my comfort, or to alleviate pain.

OTHER DIRECTIONS **(include any other directions)**:

This authorization DOES include [ ] or does NOT include [ ] the withholding or withdrawal of artificial feeding **(initial only one box above)**.

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

WARNING TO PERSON EXECUTING THIS DOCUMENT: This is an important legal document which is authorized by the general laws of this state. Before executing this document, you should know these important facts: You must be at least eighteen (18) years of age and a resident of the state of Rhode Island for this document to be legally valid and binding.

None of the following may be designated as your agent: (1) your treating health care provider, (2) a non-relative employee of your treating health care provider, (3) an operator of a community care facility, OR (4) a non-relative employee of an operator of a community care facility.

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 or mental condition.

This document gives the person you designate as your agent (the attorney-in-fact) the power to make health care decisions for you. Your agent must act consistently with your desires as stated in this document or otherwise made known. Except as you otherwise specify in this document, this document gives your agent the power to consent to your doctor not giving treatment or stopping treatment necessary to keep you alive. Notwithstanding this document, you have the right to make medical and other health care decisions for yourself so long as you can give informed consent with respect to the particular decision. In addition, no treatment may be given to you over your objection at the time, and health care necessary to keep you alive may not be stopped or withheld if you object at the time. This document gives your agent authority to consent, refuse to consent, or withdraw consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition. This power is subject to any statement of your desires and any limitation that you include in this document. You may state in this document any types of treatment that you do not desire. In addition, a court can take away the power of your agent to make health care decisions for you if your agent:
(1) authorizes anything that is illegal,
(2) acts contrary to your known desires, OR
(3) where your desires are not known, does anything that is clearly contrary to your best interests.
Unless you specify a specific period, this power will exist until you revoke it. Your agent's power and authority ceases upon your death except to inform your next of kin of your desire to be an organ and tissue donor.
You have the right to revoke the authority of your agent by notifying your agent or your treating doctor, hospital, or other health care provider orally or in writing of the revocation. Your agent has the right to examine your medical records and consent to their disclosure unless you limit this right in this document. This document revokes any prior durable power of attorney for health care. You should carefully read and follow the witnessing procedure described at the end of this form. This document will not be valid unless you comply with the witnessing procedure. If there is anything in this document that you do not understand, you should ask a lawyer to explain it to you. Your agent may need this document immediately in case of an emergency that requires a decision concerning your health care. Either keep this document where it is immediately available to your agent or give him or her an executed copy of this document. You may also want to give your doctor an executed copy of this document.

DESIGNATION OF HEALTH CARE AGENT: 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.

CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE: By this document I intend to create a durable power of attorney for health care.

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, refusing, or withdrawing life-prolonging care, treatment, services, and procedures. **(If you want to limit the authority of your agent to make health care decisions for you, you can state the 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 life-prolonging care, treatment, services, and procedures. You can also include a statement of your desires concerning other matters relating to your health care. 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 document, 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 below **(List desires and limits) (Attach additional pages if necessary)**:
Statement of desires concerning life-prolonging care, treatment, services, and procedures

Additional statement of desires, special provisions, and limitations regarding health care decisions:

You may attach additional pages if you need more space to complete your statement. If you attach additional pages, you must date and sign EACH of the additional pages at the same time you date and sign this document.)

INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY PHYSICAL AND MENTAL HEALTH: Subject to any limitations in this document, my agent has the power and authority to do all of the following: (1) Request, review, and receive any information, verbal or written, regarding my physical or mental health, including, but not limited to medical and hospital records. (2) Execute on my behalf any releases or other documents that may be required in order to obtain this information. (3) Consent to the disclosure of this information.
(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 the "Additional Statement..." space above.)

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: (1) Documents titled or purporting to be a "Refusal to Permit Treatment" and "Leaving Hospital Against Medical Advice." (2) Any necessary waiver or release from liability required by a hospital or physician.

DURATION. **(Unless you specify a shorter period in the space below, this power of attorney will exist until it is revoked.) (Initial the box and fill in a date ONLY if you want the authority of your agent to end on a specific date.)**

[ ] This durable power of attorney for health care expires on_____

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)

PRIOR DESIGNATIONS REVOKED: I revoke any prior durable powers 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 (Declaration)
[ ] 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 by Health Care Agent (Attorney-in-Fact for Health Care)

I accept my appointment as Health Care Agent (Attorney-in-Fact for Health Care):

Signature _____ Date _____

I accept my appointment as Alternate Health Care Agent (Attorney-in-Fact for Health Care)

Signature _____ Date _____