South Carolina Advance Health Care Directive

On this date of ___________________ , I, ____________________________ , being at least 18 years of age, and a resident of and domiciled in the State of South Carolina at the following address:
____
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 willfully and voluntarily make known my desire that no life-sustaining procedures be used to prolong my dying if my condition is terminal or if I am in a state of permanent unconsciousness, and I declare:

If at any time I have a condition certified to be a terminal condition by two (2) physicians who have personally examined me, one (1) of whom is my attending physician, and the physicians have determined that my death could occur within a reasonably short period of time without the use of life-sustaining procedures or if the physicians certify that I am in a state of permanent unconsciousness and where the application of life-sustaining procedures would serve only to prolong the dying process, I direct that the procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure necessary to provide me with comfort care.

INSTRUCTIONS CONCERNING ARTIFICIAL NUTRITION AND HYDRATION: If my condition is terminal and could result in death within a reasonably short time:
(Initial one of the following statements)
[ ] I direct that nutrition and hydration BE provided through any medically-indicated means, including medically- or surgically-implanted tubes.
[ ] I direct that nutrition and hydration NOT be provided through any medically-indicated means, including medically- or surgically-implanted tubes.

If I am in a persistent vegetative state or other condition of permanent unconsciousness :
(Initial one of the following statements)
[ ] I direct that nutrition and hydration BE provided through any medically-indicated means, including medically- or surgically-implanted tubes.
[ ] I direct that nutrition and hydration NOT be provided through any medically-indicated means, including medically- or surgically-implanted tubes.

In the absence of my ability to give directions regarding the use of life-sustaining procedures, it is my intention that this Declaration be honored by my family and physicians and any health facility in which I may be a patient as the final expression of my legal right to refuse medical or surgical treatment, and I accept the consequences from the refusal. I am aware that this Declaration authorizes a physician to withhold or withdraw life-sustaining procedures. I am emotionally and mentally competent to make this Declaration.

APPOINTMENT OF AN AGENT FOR REVOCATION: You may give another person authority to revoke this declaration on your behalf. If you wish to do so, please enter that person's name in the space below **(optional)**:

Name of Agent with Power to Revoke ____
Address ____

REVOCATION PROCEDURES: This declaration may be revoked by any one (1) of the following methods. However, a revocation is not effective until it is communicated to the attending physician:
(1) by being defaced, torn, obliterated, or otherwise destroyed, in expression of your intent to revoke, by you or by some person in your presence and by your direction. Revocation by destruction of one or more of multiple original declarations revokes all of the original declarations,
(2) by a written revocation signed and dated by you expressing your intent to revoke,
(3) by your oral expression of your intent to revoke the declaration. An oral revocation communicated to the attending physician by a person other than you is effective only if:
(a) the person was present when the oral revocation was made;
(b) the revocation was communicated to the physician within a reasonable time; OR
(c) your physical or mental condition makes it impossible for the physician to confirm through subsequent conversation with you that the revocation has occurred. To be effective as a revocation, the oral expression clearly must indicate your desire that the declaration not be given effect or that life-sustaining procedures be administered.
(4) if you, in the space above, have authorized an agent to revoke the declaration, then the agent may revoke orally or by a written, signed, and dated instrument. An agent may revoke only if you are incompetent to do so. An agent may revoke the declaration permanently or temporarily,
(5) by your executing another declaration at a later time.

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

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

1. This document gives the person you name as your agent the power to make health care decisions for you if you cannot make the decision for yourself. This power includes the power to make decisions about life-sustaining treatment. Unless you state other-

wise, your agent will have the same authority to make decisions about your health care as you would have.

2. This power is subject to any limitations or statements of your desires that you include in this document. You may state in this document any treatment you do not desire or treatment you want to be sure you receive. Your agent will be obligated to follow your instructions when making decisions on your behalf. You may attach additional pages if you need more space to complete the statement.

3. After you have signed this document, you have the right to make health care decisions for yourself if you are mentally competent to do so. After you have signed this document, no treatment may be given to you or stopped over your objection if you are mentally competent to make that decision.

4. You have the right to revoke this document, and terminate your agent's authority, by informing either your agent or your health care provider orally or in writing.

5. If there is anything in this document that you do not understand, you should ask a social worker, lawyer, or other person to explain it to you.

6. This power of attorney will not be valid unless two persons sign as witnesses. Each of these persons must either witness your signing of the power of attorney or witness your acknowledgment that the signature on the power of attorney is yours.

The following persons may not act as witnesses: A. Your spouse, your children, grandchildren, and other lineal descendants; your parents, grandparents, and other lineal ancestors; your siblings and their lineal descendants; or a spouse of any of these persons. B. A person who is directly financially responsible for your medical care.
C. A person who is named in your will, or, if you have no will, who would inherit your property by intestate succession. D. A beneficiary of a life insurance policy on your life. E. The persons named in the health care power of attorney as your agent or successor agent. F. Your physician or an employee of your physician. G. Any person who would have a claim against any portion of your estate (persons to whom you owe money). If you are a patient in a health facility, no more than one witness may be an employee of that facility.

7. Your agent must be a person who is 18 years old or older and of sound mind. It may not be your doctor or any other health care provider that is now providing you with treatment; or an employee of your doctor or provider; or a spouse of the doctor, provider, or employee; unless the person is a relative of yours.

8. You should inform the person that you want him or her to be your health care agent. You should discuss this document with your agent and your physician and give each a signed copy. If you are in a health care facility or a nursing care facility, a copy of this document should be included in your medical record.

DESIGNATION OF HEALTH CARE AGENT (South Carolina Statutory Form): I hereby appoint:
____ (Name)
____ (Address)
Telephone: home: _______________ work: ________________ mobile: __________________
as my agent to make health care decisions for me as authorized in this document.

SUCCESSOR AGENT: If an agent named by me dies, becomes legally disabled, resigns, refuses to act, becomes unavailable, or if an agent who is my spouse is divorced or separated from me, I name the following as successor to my agent:
____ (Name)
____(Address)
Telephone: home: _______________ work: ________________ mobile: __________________

UNAVAILABILITY OF AGENT(S): If at any relevant time the agent or successor agents named here are unable or unwilling to make decisions concerning my health care, and those decisions are to be made by a guardian, by the Probate Court, or by a surrogate pursuant to the Adult Health Care Consent Act, it is my intention that the guardian, Probate Court, or surrogate make those decisions in accordance with my directions as stated in this document.

EFFECTIVE DATE AND DURABILITY: By this document I intend to create a durable power of attorney effective upon, and only during, any period of mental incompetence, except as provided in Paragraph 3 below.

HIPAA AUTHORIZATION: When considering or making health care decisions for me, all individually identifiable health information and medical records shall be released without restriction to my health care agent(s) and/or my alternate health care agent(s) named above including, but not limited to, (i) diagnostic, treatment, other health care, and related insurance and financial records and information associated with any past, present, or future physical or mental health condition including, but not limited to, diagnosis or treatment of HIV/AIDS, sexually transmitted disease(s), mental illness, and/or drug or alcohol abuse and (ii) any written opinion relating to my health that such health care agent(s) and/or alternate health care agent(s) may have requested. Without limiting the generality of the foregoing, this release authority applies to all health information and medical records governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 USC 1320d and 45 CFR 160-164; is effective whether or not I am mentally competent; has no expiration date; and shall terminate only in the event that I revoke the authority in writing and deliver it to my health care provider.

AGENT'S POWERS: I grant to my agent full authority to make decisions for me regarding my health care. In exercising this authority, my agent shall follow my desires as stated in this document or otherwise expressed by me or known to my agent. In making any decision, my agent shall attempt to discuss the proposed decision with me to determine my desires if I am able to communicate in any way. If my agent cannot determine the choice I would want made, then my agent shall make a choice for me based upon what my agent believes to be in my best interests. My agent's authority to interpret my desires is intended to be as broad as possible, except for any restrictions or limitations I may state below.

Accordingly, unless specifically limited by the provisions specified below, my agent is authorized as follows: A. To consent, refuse, or withdraw consent to any and all types of medical care, treatment, surgical procedures, diagnostic procedures, medication, and the use of mechanical or other procedures that affect any bodily function, including, but not limited to, artificial respiration, nutritional support and hydration, and cardiopulmonary resuscitation. B. To authorize, or refuse to authorize, any medication or procedure intended to relieve pain, even though such use may lead to physical damage, addiction, or hasten the moment of, but not intentionally cause, my death. C. To authorize my admission to or discharge, even against medical advice, from any hospital, nursing care facility, or similar facility or service. D. To take any other action necessary to making, documenting, and assuring implementation of decisions concerning my health care, including, but not limited to, granting any waiver or release from liability required by any hospital, physician, nursing care provider, or other health care provider; signing any documents relating to refusals of treatment or the leaving of a facility against medical advice, and pursuing any legal action in my name, and at the expense of my estate to force compliance with my wishes as determined by my agent, or to seek actual or punitive damages for the failure to comply. E. The powers granted above do not include the following powers or are subject to the following rules or limitations:

ORGAN DONATION: **(Initial one only)** My agent [   ] may OR [   ] may not consent to the donation of all or any of my tissue or organs for purposes of transplantation, consistent with my wishes as known to my agent and/or as stated in this document.

EFFECT ON DECLARATION OF A DESIRE FOR A NATURAL DEATH (LIVING WILL): I understand that if I have a valid Declaration of a Desire for a Natural Death, the instructions contained in the Declaration will be given effect in any situation to which they are applicable. My agent will have authority to make decisions concerning my health care only in situations to which the Declaration does not apply.

STATEMENT OF DESIRES CONCERNING LIFE-SUSTAINING TREATMENT: With respect to any Life-Sustaining Treatment, I direct the following:
(Initial only one of the following 3 paragraphs)

[   ] GRANT OF DISCRETION TO AGENT. I do not want my life to be prolonged nor do I want life-sustaining treatment to be provided or continued if my agent believes the burdens of the treatment outweigh the expected benefits. I want my agent to consider the relief of suffering, my personal beliefs, the expense involved and the quality as well as the possible extension of my life in making decisions concerning life-sustaining treatment. OR

[   ] DIRECTIVE TO WITHHOLD OR WITHDRAW TREATMENT. I do not want my life to be prolonged and I do not want life-sustaining treatment: (a). If I have a condition that is incurable or irreversible and, without the administration of life-sustaining procedures, expected to result in death within a relatively short period of time; or (b). If I am in a state of permanent unconsciousness. OR

[   ] DIRECTIVE FOR MAXIMUM TREATMENT. I want my life to be prolonged to the greatest extent possible, within the standards of accepted medical practice, without regard to my condition, the chances I have for recovery, or the cost of the procedures.

STATEMENT OF DESIRES REGARDING TUBE FEEDING: With respect to Nutrition and Hydration provided by means of a nasogastric tube or tube into the stomach, intestines, or veins, I wish to make clear that in situations where life-sustaining treatment is being withheld or withdrawn pursuant to my desires stated above. **(Initial only one of the following 3 paragraphs)**

[ ] GRANT OF DISCRETION TO AGENT. I do not want my life to be prolonged by tube feeding if my agent believes the burdens of tube feeding outweigh the expected benefits. I want my agent to consider the relief of suffering, my personal beliefs, the expense involved, and the quality as well as the possible extension of my life in making this decision. OR

[ ] DIRECTIVE TO WITHHOLD OR WITHDRAW TUBE FEEDING. I do not want my life prolonged by tube feeding. OR

[ ] DIRECTIVE FOR PROVISION OF TUBE FEEDING. I want tube feeding to be provided within the standards of accepted medical practice, without regard to my condition, the chances I have for recovery, or the cost of the procedure, and without regard to whether other forms of life-sustaining treatment are being withheld or withdrawn.

IF YOU DO NOT INITIAL ANY OF THE ABOVE 3 STATEMENTS, YOUR AGENT WILL NOT HAVE AUTHORITY TO DIRECT THAT NUTRITION AND HYDRATION NECESSARY FOR COMFORT CARE OR ALLEVIATION OF PAIN BE WITHDRAWN.

STATEMENT OF ANY RESTRICTIONS OR LIMITATIONS: **(Optional. Use additional pages if necessary-However, any additional pages must be signed and dated).**

ADMINISTRATIVE PROVISIONS: I revoke any prior Health Care Power of Attorney and any provisions relating to health care of any other prior power of attorney. This power of attorney is intended to be valid in any jurisdiction in which it is presented.

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 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 UNDERSTAND THE PURPOSE AND EFFECT OF THIS DOCUMENT.

Signature ______________________________ Date ____________________

City, County, and State of Residence ____

Notary Acknowledgment

State of South Carolina

County of ____________________

On ____________________ , ______________________________ came before me personally and, under oath, subscribed to, acknowledged, and 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.

Additionally subscribed and sworn to before me by _________________________________ and________________________________, the witnesses on the same date noted above.

____

Notary Public

My commission expires ____________________

Witness Acknowledgment and Affidavit

State of South Carolina Affidavit
County of ___________

We, ______________________________ and _________________________________, the undersigned witnesses to the foregoing Advance Health Care Directive, consisting of a Declaration of a Desire for a Natural Death, an Designation of Health Care Power of Attorney, a Designation of Primary Physician, and an Organ Donation, dated the ___ day of ___________, ______, at least one of us being first duly sworn, declare to the undersigned authority, on the basis of our best information and belief, that the Advance Health Care Directive was on that date signed by the declarant/principal as and for his Advance Health Care Directive, consisting of a Declaration of a Desire for a Natural Death, an Designation of Health Care Power of Attorney, a Designation of Primary Physician, and an Organ Donation, in our presence and we, at his request and in his presence, and in the presence of each other, subscribe our names as witnesses on that date. The declarant/principal is personally known to us, and we believe him to be of sound mind and under no duress, fraud, or undue influence. Each of us affirms that he is qualified as a witness to this Advance Health Care Directive under the provisions of the South Carolina Death With Dignity Act and any other relevant provision of South Carolina law, that he or she is not related to the declarant/principal by blood, marriage, or adoption, either as a spouse, lineal ancestor, descendant of the parents of the declarant/principal, or spouse of any of them; nor directly financially responsible for the declarant/principal's medical care; nor entitled to any portion of the declarant/principal's estate upon his decease, whether under any will or as an heir by intestate succession; nor the beneficiary of a life insurance policy of the declarant/principal; nor the declarant/principal's attending physician; nor an employee of the attending physician; nor a person who has a claim against the declarant/principal's decedent's estate as of this time. Neither of us has been appointed as Health Care Agent or Successor Health Care Agent by this document. No more than one of us is an employee of a health facility in which the declarant/principal is a patient. If the declarant/principal is a resident in a hospital or nursing care facility at the date of execution of this Advance Health Care Directive, at least one of us is an ombudsman designated by the State Ombudsman, Office of the Governor.

Witness Signature ____________________________ Date ___________________

Printed Name and Address of Witness ____

Second Witness Signature ____________________________ Date __________________

Printed Name and Address 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 ___________________

Signature of Successor____________________________ Date ___________________