Advance Health Care Directive of

BY: _____ Date of Birth: _____

Using this advance directive form to do health care planning is completely optional. Other forms are also valid in Maryland. No matter what form you use, talk to your family and others close to you about your wishes during possible medical scenarios.

This form notifies others what your health care decisions are even if you cannot (or do not want to) make your own health care decisions. The person you pick is called your health care agent. Make sure you talk to your health care agent (and any back-up agents) about this important role.

This form documents your preferences about efforts to extend your life in three situations: terminal condition, persistent vegetative state, and end-stage condition. In addition to your health care planning decisions, you can choose to become an organ donor after your death by filling out additional forms.

Make sure you give a copy of the completed form to your health care agent, your doctor, and others who might need it. Keep a copy at home in a place where someone can get it if needed. Review what you have written periodically.

I, _____, (Principal) an adult of sound mind, execute this Advance Health Care Directive freely and voluntarily, with an understanding of its purposes and consequences. I intend to create this medical durable power of attorney under the laws of the State of Maryland. I further intend to demonstrate my wishes concerning medical treatment with clear and convincing evidence. I hereby revoke any Advance Health Care Directive previously granted by me as principal except powers granted by me under any state statutory Advance Health Care Directive.

Article One

Recitals

Section 1.01 Designation of Health Care Agent

I designate the individual named below to serve as my Health Care Agent. I give my Health Care Agent the power to make decisions with regard to my health care if I am unable to make my own health care decisions.

Name: _____

Address: _____

Phone: _____

Principle's Initials _____

If _____ is unwilling or unable to serve, I designate the individuals in the order listed below as alternate Health Care Agents to exercise the powers and discretions set forth in this instrument.

Name: _____

Address: _____

Phone: _____

Section 1.02 Designation of Primary Physician

I designate the physician named below as my primary physician.

Name: _____

Address: _____

Phone: _____

Section 1.03 Duration

This Advance Health Care Directive expires at the earliest of:

my divorce or the annulment of my marriage;

my death (except for post-death matters allowed under Maryland law); or

my revocation of this Advance Health Care Directive.

However, the medical information and medical records provisions described in Section 2.04 continue in effect for an additional 24 months from the date of my death unless revoked. My Health Care Agent's authority does not terminate if I become disabled or incapacitated.

Section 1.04 General Grant

My Health Care Agent may determine and implement all actions necessary for my personal care, residential placement, and medical treatment, including the items specifically mentioned in this instrument. If my Health Care Agent is not available, I intend to guide decisions about my care and treatment with the following statements.

Section 1.05 Pregnancy

My Agent may make health care decisions for me even if my Agent knows that I am pregnant.

Article Two

Health and Personal Powers

Section 2.01 Instructions Concerning Medical Evaluations and Treatment

In exercising the authority granted to my Health Care Agent, I instruct my Health Care Agent to discuss with me the specifics of any proposed decision regarding my medical care and treatment if I am able to communicate in any manner however rudimentary, even by blinking my eyes. I further instruct my Health Care Agent that if I am unable to give an informed consent to medical treatment, my Health Care Agent shall give or withhold consent based upon any treatment choices I have expressed while competent, whether under this instrument or otherwise. If my Health Care Agent cannot determine the treatment choice I would want made under the circumstances, then I request that my Health Care Agent make the choice for me based upon what my Health Care Agent believes to be in my best interests. I request that my Health Care Agent's decision be guided by taking into account:

the provisions of this instrument;

any preferences that I may have expressed on the subject;

what my Health Care Agent believes I would want done in the circumstances if I were able to express myself; and

any information given to my Health Care Agent by the physicians treating me as to my medical diagnosis and prognosis and the intrusiveness, pain, risks, and side effects of the treatment.

I want to leave my family, friends, and persons who care about me with assurances of my love, and without the burdens of guilt or conflict. My purposes in leaving these instructions are to alleviate uncertainty that otherwise may arise in connection with decisions about my medical care, to promote family harmony, and to clarify instructions to my health care providers. My Health Care Agent's authority to act on my behalf concerning my medical care includes decisions concerning artificial life support, medical treatment, surgery and other medical procedures; artificial nourishment and hydration; resuscitation decisions (including Do Not Resuscitate [DNR] orders and Cardiopulmonary Resuscitation [CPR] directives); amputation of my limbs; blood transfusions; experimental drugs and medical procedures; the administration of pharmaceutical agents; arrangements for my long-term care.

I affirm my belief in the importance and value of my personal dignity, both in living and in dying.

Section 2.02 Long-term or Hospice Care

My Health Care Agent may select a facility for my nursing, convalescent, or hospice care and establish my residence and placement in a secure unit therein if the facility provides the quality of care appropriate for my medical needs and mental condition. For the purposes of arranging or providing long-term care, my Health Care Agent has authority to facilitate my transportation and establish my legal residence within or beyond the state of Maryland.

Principle's Initials _____

Section 2.03 Maintain Me in My Residence

I authorize my Health Care Agent to take whatever steps are necessary or advisable to enable me to remain in my personal residence as long as it is reasonable under the circumstances. I realize that my health may deteriorate so that it becomes necessary to have round-the-clock nursing care if I am to remain in my personal residence, and I direct my Health Care Agent to obtain that care, including any equipment that might assist in my care, as is reasonable under the circumstances. Specifically, I do not want to be hospitalized or put in a convalescent or similar home as long as it is reasonable to maintain me in my personal residence.

Section 2.04 Medical Information and Medical Records

Acting on my behalf, my Health Care Agent may have access to all of my medical information and photocopies of my medical records from my health care providers including physicians, dentists, podiatrists, physical therapists, chiropractic physicians and chiropractors, pharmacists, optometrists, psychologists, social workers, hospitals, hospices, and other treatment facilities; may disclose medical and related information concerning my treatment to appropriate health care providers; and may admit or transfer me to such hospitals, hospices, or treatment facilities as my Health Care Agent determines to be in my best interests.

In order for my Health Care Agent to fulfill his or her duties, my treating physician or hospital is to discuss my medical condition with and disclose all medical records to my Health Care Agent.

Section 2.05 Employ and Discharge Health Care Personnel

My Health Care Agent may employ and discharge medical personnel including physicians, psychiatrists, dentists, nurses, and therapists as my Health Care Agent determines necessary for my physical, mental, and emotional well-being, and pay them reasonable compensation.

Section 2.06 Pain Relief

I want to ensure that my Health Care Agent and physician protect my comfort and freedom from pain insofar as possible. I authorize my Health Care Agent to consent on my behalf to the administration of whatever pain-relieving drugs and pain-relieving surgical procedures my Health Care Agent, upon medical advice, believes may provide comfort to me, even though such drugs or procedures may lead to pharmaceutical addictions, lower blood pressure, lower levels of breathing, or hasten my death. Even if artificial life support or aggressive medical treatment has been withdrawn or refused, I want to be kept as comfortable as possible, and I do not want to be neglected by medical or nursing staff.

Section 2.07 Consent to Psychiatric Treatment

Upon the execution of a certificate by two independent psychiatrists who have examined me and in whose opinions I am in immediate need of hospitalization because of mental disorders, alcoholism, or drug abuse, my Health Care Agent may arrange for my voluntary admission to an appropriate hospital or institution for treatment of the diagnosed problem or disorder; to arrange for private psychiatric and psychological treatment for me; and to revoke, modify, withdraw, or change consent to the hospitalization, institutionalization, or private treatment that I or my Health Care Agent may have previously given. The consent of my Health Care Agent to my hospitalization for psychiatric help,

alcoholism, or drug abuse has the same legal effect, subject to applicable local law, as a voluntary admission made by me.

Section 2.08 Grant Releases

My Health Care Agent may grant, in conjunction with any instructions given under this instrument, releases from all liability for damages suffered or to be suffered by me to hospital staff, physicians, nurses, and other medical and hospital administrative personnel who act in reliance on instructions given by my Health Care Agent or who render written opinions to my Health Care Agent in connection with any matter described in this instrument. My Health Care Agent may sign documents titled or purporting to be a *Refusal to Permit Treatment* and *Leaving Hospital Against Medical Advice* as well as any necessary waivers of or releases from liability required by any hospital or physician to implement my wishes regarding medical treatment or nontreatment.

Section 2.09 Advance Health Care Directive

I have not executed an Advance Health Care Directive and I do not want my Health Care Agent's powers to be limited by the terms or conditions of an Advance Health Care Directive.

If I become unconscious or incompetent in a state where this Advance Health Care Directive is not enforceable, I authorize my Health Care Agent to transport me or arrange for my transportation to a jurisdiction where my medical directives will be enforceable.

Section 2.10 Anatomical Gifts for Any Purposes

I authorize my Health Care Agent to make anatomical gifts on my behalf to the persons and organizations my Health Care Agent chooses for any purpose, including transplantation and medical research. My Health Care Agent may execute the papers and act as necessary, appropriate, incidental, or convenient in connection with these gifts.

Section 2.11 Autopsy and Disposition of Remains

My Health Care Agent may authorize an autopsy and direct the disposition of my remains.

Article Three

Legal and Administrative Powers and Provisions

Section 3.01 Health Insurance Portability and Accountability Act

I grant my Health Care Agent the power and authority to serve as my authorized recipient for all purposes of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and its regulations immediately upon my signing this document.

Pursuant to HIPAA, I specifically authorize my Health Care Agent as my HIPAA-authorized recipient to request, receive, and review any information regarding my physical health, including all HIPAA-

protected health information, medical, and hospital records; to execute on my behalf any authorizations, releases, or other documents that may be required to obtain this information; and to consent to the disclosure of this information. I further authorize my Health Care Agent to execute on my behalf valid authorizations for the release of HIPAA-protected health information.

By signing this Advance Health Care Directive, I specifically authorize my physician, hospital, or health care provider to release any medical records to my Health Care Agent or any person designated in a valid authorization for the release of HIPAA-protected health information executed by my Health Care Agent. Further, I waive any liability to any physician, hospital, or health care provider that releases any of my medical records to my Health Care Agent and acknowledge that the health information that would otherwise be protected under HIPAA will no longer be protected.

Section 3.02 Guardian

My Health Care Agent's authority precludes the need for appointment of a Guardian. But if any proceeding is commenced for the appointment of a Guardian, I nominate my Health Care Agent to serve as Guardian.

Section 3.03 Third-Party Reliance

My Health Care Agent's instructions and decisions regarding my medical treatment are binding on third parties. No person, medical facility, or institution will incur any liability to me or to my estate by complying with my Health Care Agent's instructions. My Health Care Agent is authorized to execute consents, waivers, and releases of liability on my behalf and on behalf of my estate to all medical personnel who comply with my Health Care Agent's instructions. Furthermore, I authorize my Health Care Agent to indemnify and hold harmless, at my expense, any third party who accepts and acts under this Advance Health Care Directive, and I agree to be bound by any indemnity entered into by my Health Care Agent.

Section 3.04 Enforcement by Health Care Agent

I authorize my Health Care Agent to seek on my behalf and at my expense:

> a declaratory judgment from any court of competent jurisdiction interpreting the validity of this instrument or any of the acts authorized by this instrument, but a declaratory judgment is not required for my Health Care Agent to perform any act authorized by this instrument;
>
> an injunction requiring compliance with my Health Care Agent's instructions by any person providing medical or personal care to me; or
>
> actual and punitive damages against any person responsible for providing medical or personal care to me who willfully fails or refuses to follow my Health Care Agent's instructions.

Principle's Initials _____

Section 3.05 Release of Health Care Agent's Personal Liability

My Health Care Agent will not incur any personal liability to me or my estate arising from the good faith exercise of discretion or performance of acts and duties relating to my medical treatment and personal care.

Section 3.06 Reimbursement of Health Care Agent

My Health Care Agent is entitled to reimbursement for all reasonable expenses arising from the performance of acts and duties relating to my medical treatment and personal care under this instrument.

Section 3.07 Copies Effective as Originals

Photocopies of this instrument are effective and enforceable as originals, and third parties are entitled to rely on photocopies of this instrument for the full force and effect of all stated terms. The word *photocopies* includes facsimiles, digital, or other reproductions.

Section 3.08 Interstate Enforceability

My intention is that the terms of this instrument be honored in any jurisdiction, regardless of its conformity to that jurisdiction's technical requirements and legal formalities.

Section 3.09 Amendment and Revocation

I reserve the right to revoke my Health Care Agent's authority orally or in writing.

Section 3.10 Revocation of Prior Powers

Unless specifically excepted in this instrument, this Advance Health Care Directive supersedes any prior medical durable power of attorney that I have executed. But this instrument does not affect any other unrelated powers previously conveyed by me through general or limited powers of attorney; these powers are to continue in full force until revoked by me or otherwise terminated.

Article Four

Definitions

Section 4.01 Shall and May

Unless otherwise specifically provided in this document or by the context in which used, I use the word *shall* in this document to impose a duty, command, direction, or requirement, and the word *may* to allow or permit, but not require. In the context of my Health Care Agent, when I use the word *shall,* I intend to impose a fiduciary duty on my Health Care Agent. When I use the word *may*, I intend that my Health Care Agent is empowered to act with sole and absolute discretion unless otherwise stated

in this document.

I ask that my agent respect my wishes as noted under the section titled 'Treatment Preferences, but and the following conditions or limitations (Optional; form valid if nothing is listed):

_____
_____
_____
_____
_____

Effectiveness of this power

My agent's power is in effect:

1. Immediately after I sign this document, subject to my right to make any decision about my health care if I want and am able to.

2. Whenever I am not able to make informed decisions about my health care, either because a doctor in charge of my care decides that I have lost this ability temporarily, or my attending physician and a consulting doctor agree that I have lost this ability permanently.

I choose option: _____ Initial: _____

TREATMENT PREFERENCES ("LIVING WILL")

A. Preference in Case of Terminal Condition

If my doctors certify that my death from a terminal condition is imminent, even if life sustaining procedures are used:

1. Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means.

_____

>>OR<<

2. Keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means.

_____

>>OR<<

3. Try to extend my life for as long as possible, using all available interventions that in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical means.

_____

B. Preference in Case of Persistent Vegetative State

If my doctors certify that I am in a persistent vegetative state, that is, if I am not conscious and am not aware of myself or my environment or able to interact with others, and there is no reasonable expectation that I will ever regain consciousness:

1. Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means.

_____

>>OR<<

2. Keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means.

_____

>>OR<<

3. Try to extend my life for as long as possible, using all available interventions that in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical means.

_____

C. Preference in Case of End-Stage Condition

If my doctors certify that I am in an end-state condition, that is, an incurable condition that will continue in its course until death and that has already resulted in loss of capacity and complete physical dependency:

1. Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means.

_____

>>OR<<

2. Keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means.

_____

>>OR<<

3. Try to extend my life for as long as possible, using all available interventions that in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical means.

_____

D. Pain Relief

No matter what my condition, give me the medicine or other treatment I need to relieve pain.

E. Effect of Stated Preferences

1. I realize I cannot foresee everything that might happen after I can no longer decide for myself. My stated preferences are meant to guide whoever is making decisions on my behalf and my health care providers, but I authorize them to be flexible in applying these statements if they feel that doing so would be in my best interest.

_____

>>OR <<

2. I realize I cannot foresee everything that might happen after I can no longer decide for myself. Still, I want whoever is making decisions on my behalf and my health care providers to follow my stated preferences exactly as written, even if they think that some alternative is better.

_____

_____

Principal Date

Principle's Initials _____

Notary acknowledgment

STATE OF MARYLAND)
) ss.
COUNTY OF _____)

On this day, _____, 20__, before me, the undersigned Notary Public, personally appeared _____, as Principal, known to me (or satisfactorily proven) to be the person whose name is subscribed to within the instrument and acknowledged that he/she executed the same in the capacity therein stated and for the purposes therein contained.

In witness whereof I hereunto set my hand and official seal.

[Notary Seal]

_____
Notary,

_____
Address

My commission expires: _____

After My Death

(This section is Optional)

BY: _____ Date of Birth: _____

Part One: Organ Donations

Initial your selections. Cross through any that you do not want.

Upon my death I wish to donate:

Any needed organs, tissues, or eyes: _____
Only the following organs, tissues, or eyes: _____

_____

_____

_____

I authorize the use of my organs, tissues, or eyes:

For transplantation: _____
For therapy: _____
For research: _____
For medical education: _____
For any purpose authorized by law: _____

I understand that no vital organ, tissue, or eye may be removed for transplantation until after I have been pronounced dead. *This document is not intended to change anything about my health care while I am still alive.* After death, I authorize any appropriate support measures to maintain the viability for transplantation of my organs, tissues, and eyes until organ, tissues, and eye recovery has been completed. I understand that my estate will not be charged for any costs related to this donation.

Part Two: Donation of Body

After any organ donation indicated in Part 1, I wish my body to be donated for use in a medical study program.

_____

Part Three: Disposition of Body and Funeral Arrangements

I want the following person to make decisions about the disposition of my body and my funeral arrangements:

1. The health care agent who I named above in my advance directive.

_____

>>OR <<

2. This person:

Name: _____

Address: _____

Telephone: _____

_____

If I have written my wishes below, they should be followed. If not the person I have named should decide based on conversations we have had, my religious or other beliefs and values, my personality, and how I reacted to other people's funeral arrangements. My wishes about the disposition of my body and my funeral arrangements are:

_____

_____

_____

Witness acknowledgment

We, _____ and _____, have been sworn by the officer signing below, and declare to that officer on our oaths that _____ (Principal) declared the instrument to be his/her Advance Health Care Directive and signed it in our presence. We each signed the instrument as a witness in the presence of _____ (Principal) and of each other.

_____ _____
Signature of Witness 1 Date

_____ _____
Witness Name (Print) Telephone Number(s)

_____ _____
Signature of Witness 2 Date

_____ _____
Witness Name (Print) Telephone Number(s)

STATE OF MARYLAND)
) ss.
COUNTY OF _____)

On this day, _____, 20__, before me, the undersigned Notary Public, personally appeared _____, in his/her capacity as Witness, and _____, in his/her capacity as Witness, known to me (or satisfactorily proven) to be the persons whose names are subscribed to within the instrument and acknowledged that they executed the same for the purposes therein contained.

In witness whereof I hereunto set my hand and official seal.

[Notary Seal]

_____
Notary,

_____
Address

My commission expires: _____

Principle's Initials _____