NEW JERSEY ADVANCE DIRECTIVE FOR HEALTH CARE

(COMBINED PROXY AND INSTRUCTION DIRECTIVE)

OF

John Doe

I understand that as a competent adult I have the right to make decisions about my health care. There may come a time when I am unable, due to physical or mental incapacity, to make my own health care decisions. In these circumstances, those caring for me will need direction concerning my care and will turn to someone who knows my values and health care wishes. I understand that those responsible for my care will seek to make health care decisions in my best interests, based upon what they know of my wishes. In order to provide the guidance and authority needed to make decisions on my behalf:

I, John Doe, currently residing at 123 Main Street, Atlantic City, New Jersey 08401, hereby declare and make known my instructions and wishes for my future health care. This advance directive for health care shall take effect in the event I become unable to make my own health care decisions, as determined by two physicians, one of which must be the physician who has primary responsibility for my care, and any necessary confirming determinations. I revoke and make null and void any and all other health care directives, living wills, and health care proxies, and medical powers of attorney previously made by me. I direct that this document become part of my permanent medical records.

_____
(Initial)

[This section appears if you choose to appoint someone to make health care decisions for you. You can appoint an alternate agent if your first choice is unavailable.]

A) CHOOSING A HEALTH CARE REPRESENTATIVE

I hereby designate:

Name:	Jane Doe
Relation:	Spouse
Address:	123 Main Street Atlantic City, New Jersey 08401
Phone:	(323) 962-8600
Alt. Phone:	(323) 962-8600
Email:	jane@legalzoom.com

as my health care representative, ("representative") to make any and all health decisions for me, including decisions to accept or to refuse any treatment, service or procedure used to diagnose or treat my physical or mental condition, and decisions to provide, withhold, or withdraw life-sustaining measures. I direct my representative to make decisions on my behalf in accordance with my wishes as stated in this document, or as otherwise known to him or her. In the event my wishes are not clear, or a situation arises I did not anticipate, my health care representative is authorized to make decisions in my best interests, based upon what is known of my wishes.

I authorize my health care representative to direct the disposition of my remains.

I authorize my health care representative to consent to an autopsy of my remains.

I have discussed the terms of this designation with my health care representative and he or she has willingly agreed to accept the responsibility for acting on my behalf.

B) ALTERNATE REPRESENTATIVES: If the person I have designated above is unable, unwilling, or unavailable to act as my health care representative, I hereby designate the following person to act as my health care representative:

Name:	Amber Doe
Relation:	Daughter
Address:	123 Main Street Atlantic City, New Jersey 08401
Phone:	(323) 962-8600
Alt. Phone:	(323) 962-8600
Email:	amber@legalzoom.com

_____
(Initial)

C) GENERAL INSTRUCTIONS: To inform those responsible for my care of my specific wishes, I make the following statement of personal views regarding my health care:

[This section will appear if you elect to be kept on life support.]

I direct that all medically appropriate measures be provided to sustain my life, regardless of my physical or mental condition.

[This section will appear if you elect to not be kept on life support and will vary depending on your choices.]

There are circumstances in which I would not want my life to be prolonged by further medical treatment. In these circumstances, life-sustaining measures should not be initiated and if they have been, they should be discontinued. I recognize that this is likely to hasten my death. In the following, I specify the circumstances in which I would choose to forego life-sustaining measures:

I realize that there may come a time when I am diagnosed as having an incurable and irreversible illness, disease, or condition. If this occurs, and my attending physician and at least one additional physician who has personally examined me determine that my condition is terminal, I direct that life-sustaining measures which would serve only to artificially prolong my dying be withheld or discontinued.

If there should come a time when I become permanently unconscious, and it is determined by my attending physician and at least one additional physician with appropriate expertise who has personally examined me, that I have totally and irreversibly lost consciousness and my capacity for interaction with other people and my surroundings, I direct that life-sustaining measures be withheld or discontinued. I understand that I will not experience pain or discomfort in this condition, and I direct that I be given all medically appropriate care necessary to provide for my personal hygiene and dignity.

I realize that there may come a time when I am diagnosed as having an incurable and irreversible illness, disease, or condition which may not be terminal. My condition may cause me to experience severe and progressive physical or mental deterioration and/or a permanent loss of capacities and faculties I value highly. If, in the course of my medical care, the burdens of continued life with treatment become greater than the benefits I experience, I direct that life-sustaining measures be withheld or discontinued.

_____
(Initial)

I also direct that I be given all medically appropriate care necessary to make me comfortable and to relieve pain, except as stated: Sample.

D) SPECIFIC INSTRUCTIONS: Artificially Provided Fluids and Nutrition; Cardiopulmonary Resuscitation (CPR).

I also direct that artificially provided fluids and nutrition, such as by feeding tube or intravenous infusion be withheld or withdrawn and that I be allowed to die.

If I should suffer a cardiac arrest, I also direct that cardiopulmonary resuscitation (CPR) not be provided and that I be allowed to die.

E) ADDITIONAL INSTRUCTIONS

[This section will appear if you write additional health care instructions.]

I further direct that*: This section is reserved for any additional health care instructions you provide.*

F) AFTER DEATH - ANATOMICAL GIFTS

[This section varies depending upon your choices regarding organ donation.]

I wish to make the following anatomical gift to take effect upon my death: Any needed organs or body parts. The anatomical gift is to be for the purposes of transplantation, therapy, medical research or education.

G) GENERAL PROVISIONS

If any provision hereof is held to be invalid, such invalidity shall not affect the other provisions of this document, and such other provisions shall be given effect without the invalid provision.

Pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and any similar state laws, and exclusively for the purpose of making a determination of my incapacitation or inability to direct my own health care decisions and obtaining a physician affidavit of such, I authorize any health care provider to disclose to the person named herein as my health care representative or alternate health care representative, as applicable, any pertinent individually identifiable health information

_____
(Initial)

sufficient to determine whether I am by reason of illness or mental or physical disability incapacitated or incapable of directing my own health care decisions. In exercising such authority, my health care representative shall constitute my "personal representative" as defined by HIPAA.

Upon the determination of my incapacitation or incapability to direct my own health care decisions, I intend for the person named herein as my health care representative or alternate health care representative, as applicable, to be treated as my "personal representative" under HIPAA and any similar state laws, and as such to be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records.

It is my intent that this document be legally binding and effective. If the law does not recognize the legal validity of this document, it is my intention that this document be taken as a formal declaration of my intentions concerning all of the above provisions. Copies of this document have the same effect as the original.

All persons or entities that in good faith endeavor to carry out the provisions of this document shall not be liable to me, my estate, or my heirs, for any damages or claims arising because of their actions or inactions based on this document. My estate shall indemnify and hold them harmless.

_____
(Initial)

H) SIGNATURE

By writing this advance directive, I inform those who may become entrusted with my health care of my wishes and intend to ease the burdens of decision making which this responsibility may impose. I have discussed the terms of this designation with my health care representative and he or she has willingly agreed to accept the responsibility for acting on my behalf in accordance with this directive. I understand the purpose and effect of this document and sign it knowingly, voluntarily and after careful deliberation.

Signed this _____ day of _____, 20_____.

_____
Signature of John Doe

123 Main Street
Atlantic City, New Jersey 08401

I) WITNESSES

Each of the undersigned witnesses states as follows: I declare that the person who signed this document, or asked another to sign this document on his or her behalf, did so in my presence, that he or she is personally known to me and that he or she appears to be of sound mind and free of duress or undue influence. I am 18 years of age or older, and am not designated by this or any other document as the person's health care representative nor as an alternate health care representative.

Date: _____

Signature: _____

Print Name: _____

Address: _____

_____

Date: _____

Signature: _____

Print Name: _____

Address: _____

_____

_____
(Initial)

These are sample documents for the State of New Jersey. Actual content differs by state and may vary based on your answers to the LegalZoom questionnaire.