

PENNSYLVANIA DURABLE HEALTH CARE POWER OF ATTORNEY AND HEALTH CARE TREATMENT INSTRUCTIONS (LIVING WILL)

OF

Jane Doe

PART I INTRODUCTORY REMARKS ON HEALTH CARE DECISION MAKING

You have the right to decide the type of health care you want.

Should you become unable to understand, make or communicate decisions about medical care, your wishes for medical treatment are most likely to be followed if you express those wishes in advance by:

- (1) naming a health care agent to decide treatment for you; and
- (2) giving health care treatment instructions to your health care agent or health care provider.

An advance health care directive is a written set of instructions expressing your wishes for medical treatment. It may contain a health care power of attorney, where you name a person called a "health care agent" to decide treatment for you, and a living will, where you tell your health care agent and health care providers your choices regarding the initiation, continuation, withholding or withdrawal of life-sustaining treatment and other specific directions.

You may limit your health care agent's involvement in deciding your medical treatment so that your health care agent will speak for you only when you are unable to speak for yourself or you may give your health care agent the power to speak for you immediately. This combined document gives your health care agent the power to speak for you only when you are unable to speak for yourself. A living will cannot be followed unless your attending physician determines that you lack the ability to understand, make or communicate health care decisions for yourself and you are either permanently unconscious or you have an end-stage medical condition, which is a

condition that will result in death despite the introduction or continuation of medical treatment. You, and not your health care agent, remain responsible for the cost of your medical care.

If you do not write down your wishes about your health care in advance, and if later you become unable to understand, make or communicate these decisions, those wishes may not be honored because they may remain unknown to others.

A health care provider who refuses to honor your wishes about health care must tell you of its refusal and help to transfer you to a health care provider who will honor your wishes.

You should give a copy of your advance health care directive (a living will, health care power of attorney or a document containing both) to your health care agent, your physicians, family members and others whom you expect would likely attend to your needs if you become unable to understand, make or communicate decisions about medical care. If your health care wishes change, tell your physician and write a new advance health care directive to replace your old one. It is important in selecting a health care agent that you choose a person you trust who is likely to be available in a medical situation where you cannot make decisions for yourself. You should inform that person that you have appointed him or her as your health care agent and discuss your beliefs and values with him or her so that your health care agent will understand your health care objectives.

You may wish to consult with knowledgeable, trusted individuals such as family members, your physician or clergy when considering an expression of your values and health care wishes. You are free to create your own advance health care directive to convey your wishes regarding medical treatment.

NOTES ABOUT THE USE OF THIS DOCUMENT

This document is designed to give your health care agent broad powers to make health care decisions for you whenever you cannot make them for yourself. It is also designed to express a desire to limit or authorize care if you have an end-stage medical condition or are permanently unconscious. It is particularly important that you consult with your attorney and physician to make sure that your wishes are clearly expressed.

This document allows you to tell your health care agent your goals if you have an end-stage medical condition or other extreme and irreversible medical condition, such as advanced Alzheimer's disease. Do you want medical care applied aggressively in these situations or would you consider such aggressive medical care burdensome and undesirable?

You may choose whether you want your health care agent to be bound by your instructions or whether you want your health care agent to be able to decide at the time what course of treatment the health care agent thinks most fully reflects your wishes and values.

If you are a woman and diagnosed as being pregnant at the time a health care decision would otherwise be made pursuant to this form, the laws of this Commonwealth prohibit implementation of that decision if it directs that life-sustaining treatment, including nutrition and hydration, be withheld or withdrawn from you, unless your attending physician and an obstetrician who have examined you certify in your medical record that the life-sustaining treatment:

- (1) will not maintain you in such a way as to permit the continuing development and live birth of the unborn child;
- (2) will be physically harmful to you; or
- (3) will cause pain to you that cannot be alleviated by medication.

A physician is not required to perform a pregnancy test on you unless the physician has reason to believe that you may be pregnant.

Pennsylvania law protects your health care agent and health care providers from any legal liability for following in good faith your wishes as expressed in the document or by your health care agent's direction. It does not otherwise change professional standards or excuse negligence in the way your wishes are carried out. If you have any questions about the law, consult an attorney for guidance.

This document and explanation is not intended to take the place of specific legal or medical advice for which you should rely upon your own attorney and physician.

**PART II
DURABLE HEALTH CARE
POWER OF ATTORNEY**

I, Jane Doe of Allegheny County, Pennsylvania, appoint the person named below to be my health care agent to make health and personal care decisions for me.

I revoke and make null and void any and all durable health care powers of attorney previously made by me.

Effective immediately and continuously until my death or revocation by a writing signed by me or someone authorized to make health care treatment decisions for me, I authorize all health care providers or other covered entities to disclose to my health care agent, upon my agent's request, any information, oral or written, regarding my physical or mental health, including, but not limited to, medical and hospital records and what is otherwise private, privileged, protected or personal health information, such as health information as defined and described in the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191, 110 Stat. 1936), the regulations promulgated thereunder and any other State or local laws and rules. Information disclosed by a health care provider or other covered entity may be redisclosed and may no longer be subject to the privacy rules provided by 45 C.F.R. Pt. 164.

The remainder of this document will take effect when and only when I lack the ability to understand, make or communicate a choice regarding a health or personal care decision as verified by my attending physician. My health care agent may not delegate the authority to make decisions.

[This section varies if you place limitations on your agent's authority.]

MY HEALTH CARE AGENT HAS ALL OF THE FOLLOWING POWERS SUBJECT TO THE HEALTH CARE TREATMENT INSTRUCTIONS THAT FOLLOW IN PART III:

1. To authorize, withhold or withdraw medical care and surgical procedures.
2. To authorize, withhold or withdraw nutrition (food) or hydration (water) medically supplied by tube through my nose, stomach, intestines, arteries or veins.
3. To authorize my admission to or discharge from a medical, nursing, residential or similar facility and to make agreements for my care and health insurance for my care, including hospice and/or palliative care.

4. To hire and fire medical, social service and other support personnel responsible for my care.
5. To take any legal action necessary to do what I have directed.
6. To consent to an autopsy of my remains.

[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.]

APPOINTMENT OF HEALTH CARE AGENT

I appoint the following health care agent ("agent"):

Name: John Doe
Relation: Spouse
Address: 100 Main Street
Pittsburgh, Pennsylvania 65889
Phone: (800) 555-1234
Alt. Phone: (800) 555-1234
Email: jdoe@legalzoomsample.com

If my health care agent is not readily available or if my health care agent is my spouse and an action for divorce is filed by either of us after the date of this document, I appoint the person named below.

Name: Ann Doe
Relation: Daughter
Address: 100 Main Street
Philadelphia, Pennsylvania 74558
Phone: (888) 555-1234
Alt. Phone: (888) 555-1234
Email: adoe@legalzoomsample.com

SEVERE BRAIN DAMAGE OR BRAIN DISEASE

If I should suffer from severe and irreversible brain damage or brain disease with no realistic hope of significant recovery, I would consider such a condition intolerable and the application of aggressive medical care to be burdensome. I therefore request that my health care agent respond to any intervening (other and separate) life-threatening conditions in the same manner as directed for an end-stage medical condition or state of permanent unconsciousness as I have indicated below.

____ (initial) I agree

____ (initial) I disagree

[This section will appear if you select living will and it varies depending on your life support choices.]

**PART III
HEALTH CARE TREATMENT INSTRUCTIONS IN THE EVENT OF END-STAGE
MEDICAL CONDITION OR PERMANENT UNCONSCIOUSNESS
(LIVING WILL)**

The following health care treatment instructions exercise my right to make my own health care decisions. These instructions are intended to provide clear and convincing evidence of my wishes to be followed when I lack the capacity to understand, make or communicate my treatment decisions:

I, Jane Doe, willfully and voluntarily make known my desire to prolong my life as long as reasonably possible within the limits of generally accepted health care standards.

I revoke and make null and void any and all other health care directives and living wills previously made by me.

LEGAL PROTECTION

Pennsylvania law protects my health care agent and health care providers from any legal liability for their good faith actions in following my wishes as expressed in this document or in complying with my health care agent's direction. On behalf of myself, my executors and heirs, I further hold my health care agent and my health care providers harmless and indemnify them against any claim for their good faith actions in recognizing my health care agent's authority or in following my treatment instructions.

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

**PART IV
ORGAN DONATION**


I consent to donate my organs and tissues at the time of my death for the purpose of transplant.

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SAMPLE

**PART V
SIGNATURE**

Having carefully read this document, I have signed it this ____ day of _____,
20 ____, revoking all previous health care powers of attorney and health care treatment
instructions.

Signature of Jane Doe

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SAMPLE

**PART VI
WITNESS**

Under penalty of perjury, each of the undersigned declares that: (1) Jane Doe has been personally known to me (or that the individual's identity was proven to me by convincing evidence), and I believe him or her to be of sound mind and not under duress, fraud or undue influence; (2) Jane Doe signed or acknowledged this document in my presence, and I did not sign Jane Doe's signature; (3) I am not related to Jane Doe by blood, adoption, or marriage; (4) I am not entitled to any part of Jane Doe's estate or directly financially responsible for his or her medical care; (5) I am competent and at least eighteen years of age; (6) I am not Jane Doe's doctor or physician, or an employee of Jane Doe's doctor or physician; and (7) I am not the operator or an employee of a community care facility or a residential care facility for the elderly.

Date: _____

Signature: _____

Print Name: _____

Address: _____

Date: _____

Signature: _____

Print Name: _____

Address: _____

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