# GEORGIA ADVANCE DIRECTIVE FOR HEALTH CARE

# OF

# Jane Doe

By: Jane Doe Date of Birth: January 1, 1976

**[The following paragraphs vary depending on your choices regarding naming a health care agent, treatment preferences, guardianship, and organ donation.]**

*This advance directive for health care has four parts:*

PART I: HEALTH CARE AGENT. *This part allows you to choose someone to make health care decisions for you when you cannot (or do not want to) make health care decisions for yourself. The person you choose is called a health care agent. You may also have your health care agent make decisions for you after your death with respect to an autopsy, organ donation, body donation, and final disposition of your body. You should talk to your health care agent about this important role.*

PART II: TREATMENT PREFERENCES. *This part allows you to state your treatment preferences if you have a terminal condition or if you are in a state of permanent unconsciousness. PART TWO will become effective only if you are unable to communicate your treatment preferences. Reasonable and appropriate efforts will be made to communicate with you about your treatment preferences before PART TWO becomes effective. You should talk to your family and others close to you about your treatment preferences.*

PART III: GUARDIANSHIP. *This part allows you to nominate a person to be your guardian should one ever be needed.*

PART IV: ORGAN DONATION. *This part allows you to state your wishes regarding organ and tissue donation upon your death.*

PART V: EFFECTIVENESS AND SIGNATURES. *This part requires your signature and the signatures of two witnesses.*

*You must fill out PART V of this document in order for this document to be effective.*

*You should give a copy of this completed document to people who might need it, such as your health care*

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*agent, your family, and your physician. Keep a copy of this completed document at home in a place where it can easily be found if it is needed. Review this completed document periodically to make sure it still reflects your preferences. If your preferences change, complete a new advance directive for health care.*

*You may revoke this completed document at any time. This completed document will replace any advance directive for health care, durable power of attorney for health care, health care proxy, or living will that you have completed before completing this document.*

**[Part I 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.]**

## PART I: HEALTH CARE AGENT

### (1) HEALTH CARE AGENT

I select the following person as my health care agent ("agent") to make health care decisions for me:

Name: John Doe
Relation: Spouse
Address: 100 Main Street
[CITY], Georgia [ZIP]
Phone: (555) 555-5555
Alt. Phone: (444) 444-4444
Email: jdoe@legalzoomsample.com

### (2) BACK-UP HEALTH CARE AGENT

If my health care agent cannot be contacted in a reasonable time period and cannot be located with reasonable efforts or for any reason my health care agent is unavailable or unable or unwilling to act as my health care agent, then I select the following, each to act successively in the order named, as my back-up health care:

Name: Ann Doe
Relation: Daughter
Address: 100 Main Street
[CITY], Georgia [ZIP]
Phone: (333) 333-3333

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Alt. Phone: (222) 222-2222
Email: adoe@legalzoomsample.com

**(3) GENERAL POWERS OF HEALTH CARE AGENT**

My health care agent will make health care decisions for me when I am unable to communicate my health care decisions or I choose to have my health care agent communicate my health care decisions.

My health care agent will have the same authority to make any health care decision that I could make. My health care agent's authority includes, for example, the power to:

- Admit me to or discharge me from any hospital, skilled nursing facility, hospice, or other health care facility or service;
- Request, consent to, withhold, or withdraw any type of health care; and
- Contract for any health care facility or service for me, and to obligate me to pay for these services (and my health care agent will not be financially liable for any services or care contracted for me or on my behalf).

My health care agent will be my personal representative for all purposes of federal or state law related to privacy of medical records (including the Health Insurance Portability and Accountability Act of 1996) and will have the same access to my medical records that I have and can disclose the contents of my medical records to others for my ongoing health care.

My health care agent may accompany me in an ambulance or air ambulance if in the opinion of the ambulance personnel protocol permits a passenger and my health care agent may visit or consult with me in person while I am in a hospital, skilled nursing facility, hospice, or other health care facility or service if its protocol permits visitation.

My health care agent may present a copy of this advance directive for health care in lieu of the original and the copy will have the same meaning and effect as the original.

**[The following section appears if you place limitations on your agent's authority.]**

The authority of my surrogate is limited as follows: Sample.

I understand that under Georgia law:

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- My health care agent may refuse to act as my health care agent;

- A court can take away the powers of my health care agent if it finds that my health care agent is not acting properly; and

- My health care agent does not have the power to make health care decisions for me regarding psychosurgery, sterilization, or treatment or involuntary hospitalization for mental or emotional illness, developmental disability, or addictive disease.

**(4) GUIDANCE FOR HEALTH CARE AGENT**

When making health care decisions for me, my health care agent should think about what action would be consistent with past conversations we have had, my treatment preferences as expressed in this document, my religious and other beliefs and values, and how I have handled medical and other important issues in the past. If what I would decide is still unclear, then my health care agent should make decisions for me that my health care agent believes are in my best interest, considering the benefits, burdens, and risks of my current circumstances and treatment options.

**(5) INDEMNITY**

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.

**(6) POWERS OF HEALTH CARE AGENT AFTER DEATH**

A. AUTOPSY

With regards to the autopsy of my body, my health care agent's authority is as follows:

My health care agent will NOT have the power to authorize an autopsy of my body (unless an autopsy is required by law).

B. ORGAN DONATION AND DONATION OF BODY

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My health care agent will have the power to make a disposition of any part or all of my body for medical purposes pursuant to the Georgia Revised Uniform Anatomical Gift Act, unless I have limited my health care agent's power by initialing below:

_____ (Initials) My health care agent will not have the power to make a disposition of my body for the use in a medical study program.

_____ (Initials) My health care agent will not have the power to donate any of my organs.

C. FINAL DISPOSITION OF BODY

My health care agent will have the power to make decisions about the final disposition of my body.

**[The following section varies depending on your choices regarding the disposition of your remains.]**

I wish for my body to be treated in the following manner: Buried. I further direct the following: Sample.

**[Part II appears if you choose to state your wishes regarding life support and will vary depending on your choices.]**

## PART II: TREATMENT PREFERENCES

**(7) CONDITIONS**

PART II will be effective if I am in any of the following conditions:

A terminal condition, which means I have an incurable or irreversible condition that will result in my death in a relatively short period of time.

A state of permanent unconsciousness, which means I am in an incurable or irreversible condition in which I am not aware of myself or my environment and I show no behavioral response to my environment.

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My condition will be determined in writing after personal examination by my attending physician and a second physician in accordance with currently accepted medical standards.

## (8) TREATMENT PREFERENCES

**[The following paragraph will appear if you elect to be kept on life support.]**

If I am in any condition that I initialed in Section (7) above and I can no longer communicate my treatment preferences after reasonable and appropriate efforts have been made to communicate with me about my treatment preferences, then try to extend my life for as long as possible, using all medications, machines, or other medical procedures that in reasonable medical judgment could keep me alive. If I am unable to take nutrition or fluids by mouth, then I want to receive nutrition or fluids by tube or other medical means.

**[The following paragraphs will appear if you elect not to be kept on life support and will vary depending on your choices.]**

If I am in any condition that I initialed in Section (7) above and I can no longer communicate my treatment preferences after reasonable and appropriate efforts have been made to communicate with me about my treatment preferences, then allow my natural death to occur. I do not want any medications, machines, or other medical procedures that in reasonable medical judgment could keep me alive but cannot cure me, except as follows:

A. If I am unable to take nutrition by mouth, I want to receive nutrition by tube or other medical means.

B. If I am unable to take fluids by mouth, I want to receive fluids by tube or other medical means.

C. If my heart or pulse has stopped, I want to have cardiopulmonary resuscitation (CPR) used.

D. I desire to receive treatment for comfort or to alleviate pain except: Sample.

## (9) ADDITIONAL STATEMENTS

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

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I further direct that: [FURTHER DIRECTIVES].

**(10) IN CASE OF PREGNANCY**

**[This section will appear if you elect not to be kept on life support and if you are female.]**

I understand that under Georgia law, my Treatment Preference generally will have no force and effect if I am pregnant unless the fetus is not viable and I indicate by initialing below that I want PART II to be carried out.

_____ (Initials) I want my treat preferences to be carried out if my fetus is not viable.

**(11) INDEMNITY**

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

**[Part III appears if you choose to appoint someone to serve as your guardian. You can appoint an alternate guardian if your first choice is unavailable.]**

## PART III: GUARDIANSHIP

**(12) GUARDIANSHIP**

**[The following statement appears if you choose your agents to serve as your guardian.]**

I nominate the person serving as my health care agent under PART I to serve as my guardian, in the order named.

**[The following statement appears if you choose someone other than your agent to serve as your guardian.]**

I nominate the following person, each to act successively in the order named, serve as my

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guardian:

**Guardian**
Name: Jack Doe
Relation: Son
Address: 100 Main Street
[CITY], Georgia [ZIP]
Phone: (777) 777-7777
Alt. Phone: (888) 888-8888
Email: jackd@legalzoomsample.com

**Alternate Guardian**
Name: Mary Smith
Relation: Mother
Address: 100 Main Street
[CITY], Georgia [ZIP]
Phone: (999) 999-9999
Alt. Phone: (111) 111-1111
Email: msmith@legalzoomsample.com

**[Part IV varies depending upon your choices regarding organ donation.]**

## PART IV: ORGAN DONATION

### (13) ORGAN DONATION

I hereby make this anatomical gift, if medically acceptable, to take effect upon my death.

I give any needed organs or parts. This gift is to be donated for medical purposes, education and research only.

## PART V: EFFECTIVENESS AND SIGNATURES

### (14) PRINCIPAL'S SIGNATURE

This advance directive for health care will become effective only if I am unable or choose not to make or communicate my own health care decisions.

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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. Copies of this document have the same effect as the original.

This document revokes any advance directive for health care, durable power of attorney for health care, health care proxy, or living will that I have completed before this date.

By signing below, I state that I am emotionally and mentally capable of making this advance directive for health care and that I understand its purpose and effect.

_____ _____

(Signature of Jane Doe) (Date)

100 Main Street
[CITY], Georgia [ZIP]

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**(15) WITNESSES' SIGNATURE**

The declarant signed this form in my presence or acknowledged signing this form to me. Based upon my personal observation, Jane Doe appeared to be emotionally and mentally capable of making this advance directive for health care and signed this document willingly and voluntarily.

Date: _____

Signature: _____

Print Name: _____

Address: _____

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Date: _____

Signature: _____

Print Name: _____

Address: _____

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