ALABAMA ADVANCE DIRECTIVE FOR HEALTH CARE

(LIVING WILL AND HEALTH CARE PROXY)

of

Jane Doe

SECTION 1: LIVING WILL

I, Jane Doe, being of sound mind and at least 19 years old, would like to make the following wishes known. I direct that my family, my doctors and health care workers, and all others follow the directions I am writing down. I know that at any time I can change my mind about these directions by tearing up this document and writing a new one. I can also do away with these directions by tearing them up and by telling someone at least 19 years of age of my wishes and asking him or her to write them down.

I understand that these directions will only be used if I am not able to speak for myself.

[This section varies depending upon your choices regarding life support.]

IF I BECOME TERMINALLY ILL OR INJURED:

Terminally ill or injured is when my doctor and another doctor decide that I have a condition that cannot be cured and that I will likely die in the near future from this condition.

Life sustaining treatment: Life sustaining treatment includes drugs, machines, or medical procedures that would keep me alive but would not cure me. I know that even if I choose not to have life sustaining treatment, I will still get medicines and treatments that ease my pain and keep me comfortable.

I do not want to have life sustaining treatment if I am terminally ill or injured.

Artificially provided food and hydration (food and water through a tube or an IV): I understand that if I am terminally ill or injured I may need to be given food and water through a tube or an IV to keep me alive if I can no longer chew or swallow on my own or with someone helping me.

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I want to have food and water provided through a tube or an IV if I am terminally ill or injured.

[This section varies depending upon your choices regarding life support.]

IF I BECOME PERMANENTLY UNCONSCIOUS:

Permanent unconsciousness is when my doctor and another doctor agree that within a reasonable degree of medical certainty I can no longer think, feel anything, knowingly move, or be aware of being alive. They believe this condition will last indefinitely without hope for improvement and have watched me long enough to make that decision. I understand that at least one of these doctors must be qualified to make such a diagnosis.

Life sustaining treatment: Life sustaining treatment includes drugs, machines, or other medical procedures that would keep me alive but would not cure me. I know that even if I choose not to have life sustaining treatment, I will still get medicines and treatments that ease my pain and keep me comfortable.

I do not want to have life-sustaining treatment if I am permanently unconscious.

Artificially provided food and hydration (Food and water through a tube or an IV): I understand that if I become permanently unconscious, I may need to be given food and water through a tube or an IV to keep me alive if I can no longer chew or swallow on my own or with someone helping me.

I want to have food and water provided through a tube or an IV if I am permanently unconscious.

OTHER DIRECTIONS:

I desire to receive treatment for comfort or to alleviate pain except: If they are addictive.

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

In addition to the directions I have listed on this document, I also want the following: Sample.

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SECTION 2: IF I NEED SOMEONE TO SPEAK FOR ME

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

PROXY APPOINTMENT

I want the person listed below to be my health care proxy. I have talked with this person about my wishes.

First choice for proxy

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

If this person is not able, not willing, or not available to be my health care proxy, this is my next choice:

Second choice for proxy

Name: Ann Doe
Relation: Daughter
Address: 100 Main Street
[CITY], Alabama [ZIP]
Phone: (333) 333-3333
Alt. Phone: (222) 222-2222
Email: adoe@legalzoomsample.com

INSTRUCTIONS FOR PROXY

I fully understand, and intend, that this designation will permit my proxy to make health care decisions and to provide, withhold, or withdraw consent on my behalf; to apply for public benefits to defray the cost of healthcare; to have access to my records necessary to make decisions or apply for benefits; and to authorize my admission to or transfer from a health care facility. I specifically give my agent the power and authority to choose my health care providers, to provide, withdraw, or withhold consent to the provision of life-prolonging procedures on my behalf; and to execute all documents,

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waivers and releases related to any of the foregoing and the powers set forth in the previous sentence. My agent must act consistently with my desires as outlined in my living will, if any.

I want my health care proxy to follow my directions as listed on this document and to make any decisions about things I have not covered in the document.

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

Notwithstanding the foregoing, the authority of my agent is limited as follows: Sample.

I authorize my agent to consent to an autopsy of my remains.

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

SECTION 3: ANATOMICAL GIFTS

I hereby authorize the making of anatomical gifts of the following parts of my body for the following purposes:

Gift: All organs and parts.
Purpose: Medical purposes, education and research.

SECTION 4: THE THINGS LISTED ON THIS DOCUMENT ARE WHAT I WANT

I revoke and make null and void any and all other health care directives, living wills, health care proxy and powers of attorney for health care previously made by me.

I understand the following:

If my doctor or hospital does not want to follow the directions I have listed, they must see that I get to a doctor or hospital who will follow my directions.

If I am pregnant, or if I become pregnant, the choices I have made on this document will not be followed until after the birth of the baby.

If the time comes for me to stop receiving life sustaining treatment or food and water through a tube or an IV, I direct that my doctor talk about the good and bad points of doing this, along with my wishes, with my health care proxy, if I have one.

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 agent or alternate health care agent, as applicable, any pertinent individually identifiable health information 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 agent shall constitute my "personal representative" as defined by HIPAA.

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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 agent or alternate health care agent, as applicable, to be treated as my "personal representative" under HIPAA and any similar state law, 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.

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SECTION 5: MY SIGNATURE

IN WITNESS WHEREOF, I have signed my name to this Advance Directive for Heath Care on the date set forth below.

_____
Signature of Jane Doe

Dated: _____, 20___

100 Main Street
[CITY], Alabama [ZIP]

Date of Birth: 01/01/1989

SECTION 6: WITNESSES

I am witnessing this document because I believe this person to be of sound mind. I did not sign the person's signature, and I am not the health care proxy. I am not related to the person by blood, adoption, or marriage and not entitled to any part of his or her estate. I am at least 19 years of age and am not directly responsible for paying for his or her medical care.

Date: _____
Signature: _____
Print Name: _____
Address: _____
_____

Date: _____
Signature: _____
Print Name: _____
Address: _____
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SECTION 7: SIGNATURE OF PROXY

SIGNATURE OF FIRST CHOICE FOR PROXY

I, John Doe, am willing to serve as the health care proxy.

_____
Signature of John Doe

Dated: _____, 20___

SIGNATURE OF SECOND CHOICE FOR PROXY:

I, Ann Doe, am willing to serve as the health care proxy if the first choice cannot serve.

_____
Signature of Ann Doe

Dated: _____, 20___

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