HEALTH CARE DIRECTIVE

(LIVING WILL / HEALTH CARE POWER OF ATTORNEY)

OF

Jane Doe

I, Jane Doe, being of sound mind and disposing mind and memory, do hereby make and declare this to be my Health Care Directive, thereby revoking and making null and void any and all other living wills and health care powers of attorney heretofore made by me.

I. LIVING WILL

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

A. I willfully and voluntarily make known my desire to prolong my life as reasonably possibly within the limits of generally accepted health care standards.

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

A. If I have been diagnosed by two physicians that any of the following are true:

- I have an incurable and irreversible condition that will result in my death within a relatively short time without the administration of life-sustaining treatment
- I am in an irreversible coma
- I am in a persistent vegetative state

and I am no longer able to make decisions regarding my medical treatment, I willfully and voluntarily make known my desire not to be kept alive with artificial life support systems and direct my attending physician to withhold or

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withdraw treatment that only prolongs my life and is not necessary for my comfort or to alleviate pain.

If I have a condition stated above, it is my preference to receive artificially administered nutrition and hydration (food and fluids).

If I am pregnant, and that fact is known to my physician, this section will have no force or effect during that pregnancy.

B. I desire to receive treatment for comfort or to alleviate pain except: If it is addictive.

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

C. I further direct that: Please make sure that I will not feel any pain.

[Section II varies depending upon your choices regarding organ donation.]

II. 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 III 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.]

III. POWER OF ATTORNEY FOR HEALTH CARE

A. In the event that I have been determined by two physicians to be incapacitated to provide informed consent for medical treatment and surgical and diagnostic procedures, I wish to designate as my agent for health care decisions:

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Name: John Doe
Address: 100 Main Street
[CITY], Arkansas [ZIP]
Phone: (800) 555-1234
Relation: Husband

If my agent is unable or is unwilling to perform his or her duties, I designate as my alternate agent:

Name: Ann Doe
Address: 100 Main Street
[CITY], Arkansas [ZIP]
Phone: (800) 555-1234
Relation: Daughter

B. I fully understand, and intend, that this designation will permit my designee 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 provide, withdraw, or withhold consent to the provision of life-prolonging procedures on my behalf; and to execute all documents, 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.

[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: I do not wish my agent to decide which organs to donate. I want as many as possible to be donated.

C. I authorize my agent to direct the disposition of my remains.

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

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(Signature)

IV. GENERAL PROVISIONS

A. 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.

B. 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.

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.

C. 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.

[The following paragraph only appears if you choose to protect your agents from liability so long as they act in good faith.]

D. 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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(Signature)

IN WITNESS WHEREOF, I have executed this document on the date below:

_____
Signature of Jane Doe

Dated: _____, 20___

100 Main Street
[CITY], Arkansas [ZIP]

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(Signature)

WITNESS DECLARATIONS

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: _____

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Date: _____

Signature: _____

Print Name: _____

Address: _____

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(Signature)