# NORTH CAROLINA HEALTH CARE DIRECTIVE

# (HEALTH CARE POWER OF ATTORNEY/LIVING WILL)

# OF

# Jane Doe

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**[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.]**

## HEALTH CARE POWER OF ATTORNEY

**NOTE: YOU SHOULD USE THIS DOCUMENT TO NAME A PERSON AS YOUR HEALTH CARE AGENT IF YOU ARE COMFORTABLE GIVING THAT PERSON BROAD AND SWEEPING POWERS TO MAKE HEALTH CARE DECISIONS FOR YOU. THERE IS NO LEGAL REQUIREMENT THAT ANYONE EXECUTE A HEALTH CARE POWER OF ATTORNEY.**

***EXPLANATION:*** *You have the right to name someone to make health care decisions for you when you cannot make or communicate those decisions. This form may be used to create a health care power of attorney, and meets the requirements of North Carolina law. However, you are not required to use this form, and North Carolina law allows the use of other forms that meet certain requirements. If you prepare your own health care power of attorney, you should be very careful to make sure it is consistent with North Carolina law.*

*This document gives the person you designate as your health care agent broad powers to make health care decisions for you when you cannot make the decision yourself or cannot communicate your decision to other people. You should discuss your wishes concerning life-prolonging measures, mental health treatment, and other health care decisions with your health care agent. Except to the extent that you express specific limitations or restrictions in this form, your health care agent may make any health care decision you could make yourself.*

*This form does not impose a duty on your health care agent to exercise granted powers, but when a power is exercised, your health care agent will be obligated to use due care to act in your best interests and in accordance with this document.*



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*This Health Care Power of Attorney form is intended to be valid in any jurisdiction in which it is presented, but places outside North Carolina may impose requirements that this form does not meet.*

*If you want to use this form, you must complete it, sign it, and have your signature witnessed by two qualified witnesses and proved by a notary public. Follow the instructions about which choices you can initial very carefully. Do not sign this form until two witnesses and a notary public are present to watch you sign it. You then should give a copy to your health care agent and to any alternates you name. You should consider filing it with the Advance Health Care Directive Registry maintained by the North Carolina Secretary of State:* http://www.nclifelinks.org/ahcdr/

**1. Designation of Health Care Agent.**

I, Jane Doe, being of sound mind, hereby appoint the following persons to serve as my health care agents to act for me and in my name (in any way I could act in person) to make health care decisions for me as authorized in this document. My designated health care agents shall serve alone, in the order named.

A. Name: John Doe — Relationship: Spouse
Address: 100 Main Street — Phone: (555) 555-5555
[CITY], North Carolina [ZIP} — Alt. Phone: (444) 444-4444
Email: jdoe@legalzoomsample.com

B. Name: Ann Doe — Relationship: Daughter
Address: 100 Main Street — Phone: (333) 333-3333
[CITY], North Carolina [ZIP] — Alt. Phone: (222) 222-22222
Email: adoe@legalzoomsample.com

Any successor health care agent designated will be vested with the same powers and duties as if originally named as my health care agent, and shall serve any time his or her predecessor is not reasonably available or is unwilling or unable to serve in that capacity.

**2. Effectiveness of Appointment.**

My designation of a health care agent expires only when I revoke it. Absent revocation, the authority granted in this document will become effective when and if two physicians (one of whom may be my attending physician) determine that I lack capacity to make or communicate decisions relating to my health care, and will continue in effect during that incapacity or until my death, except if I authorize my health care agent to exercise my rights with respect to anatomical gifts, autopsy, or disposition of my remains, this authority will continue after my death to the extent necessary to exercise that authority.

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**3. Revocation.**

Any time while I am competent, I may revoke this power of attorney in a writing I sign or by communicating my intent to revoke in any clear and consistent manner to my health care agent or my health care provider.

**4. General Statement of Authority Granted.**

Subject to any restrictions set forth in Section 5 below, I grant to my health care agent full power and authority to make and carry out all health care decisions for me. These decisions include, but are not limited to:

A. Requesting, reviewing, and receiving any information, verbal or written, regarding my physical or mental health, including, but not limited to, medical and hospital records, and consenting to the disclosure of this information.

B. Employing or discharging my health care providers.

C. Consenting to and authorizing my admission to and discharge from a hospital, nursing or convalescent home, hospice, long-term care facility, or other health care facility.

D. Consenting to and authorizing my admission to and retention in a facility for the care or treatment of mental illness.

E. Consenting to and authorizing the administration of medications for mental health treatment and electroconvulsive treatment (ECT) commonly referred to as "shock treatment."

F. Giving consent for, withdrawing consent for, or withholding consent for X-ray, anesthesia, medication, surgery, and all other diagnostic and treatment procedures ordered by or under the authorization of a licensed physician, dentist, podiatrist, or other health care provider. This authorization specifically includes the power to consent to measures for relief of pain.

G. Authorizing the withholding or withdrawal of life-prolonging measures.

H. Providing my medical information at the request of any individual acting as my attorney-in-fact under a durable power of attorney or as a trustee or successor trustee

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under any trust agreement of which I am a grantor or trustee, or at the request of any other individual whom my health care agent believes should have such information. I desire that such information be provided whenever it would expedite the prompt and proper handling of my affairs or the affairs of any person or entity for which I have some responsibility. In addition, I authorize my health care agent to take any and all legal steps necessary to ensure compliance with my instructions providing access to my protected health information. Such steps include resorting to any and all legal procedures in and out of courts as may be necessary to enforce my rights under the law and include attempting to recover attorneys' fees against anyone who does not comply with this health care power of attorney.

I. To the extent I have not already made valid and enforceable arrangements during my lifetime that have not been revoked, exercising any right I may have to authorize an autopsy or direct the disposition of my remains.

J. Taking any lawful actions that may be necessary to carry out these decisions, including, but not limited to: (i) signing, executing, delivering, and acknowledging any agreement, release, authorization, or other document that may be necessary, desirable, convenient, or proper in order to exercise and carry out any of these powers; (ii) granting releases of liability to medical providers or others; and (iii) incurring reasonable costs on my behalf related to exercising these powers, provided that this health care power of attorney does not give my health care agent general authority over my property or financial affairs.

**5. Special Provisions and Limitations.**

Except those provisions and limitations below, there are no special limitations on my agent's authority.

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

A. Limitations Concerning Health Care Decisions. In exercising the authority to make health care decisions on my behalf, the authority of my health care agent is subject to the following special provisions: Sample.

**[The following section will vary based upon your selection regarding guardianship.]**

**6. Guardianship Provision.**

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If it becomes necessary for a court to appoint a guardian of my person, I nominate the following persons, in the order named, to serve without bond or security. The guardian shall act consistently with G.S. 35A-1201(a)(5).

A. Name: Jacky Doe
Address: 100 Main Street
[CITY], North Carolina [ZIP]
Email: jadoe@legalzoomsample.com
Relationship: Mother
Phone: (111) 111-1111
Alt. Phone: (777) 777-7777

B. Name: Jeffrey Doe
Address: 100 Main Street
[CITY], North Carolina [ZIP]
Email: jedoe@legalzoomsample.com
Relationship: Father
Phone: (888) 888-8888
Alt. Phone: (999) 999-9999

**7. Reliance of Third Parties on Health Care Agent.**

A. No person who relies in good faith upon the authority of or any representations by my health care agent will be liable to me, my estate, my heirs, successors, assigns, or personal representatives for actions or omissions in reliance on that authority or those representations.

B. The powers conferred on my health care agent by this document may be exercised by my health care agent alone, and my health care agent's signature or action taken under the authority granted in this document may be accepted by persons as fully authorized by me and with the same force and effect as if I were personally present, competent, and acting on my own behalf. All acts performed in good faith by my health care agent pursuant to this power of attorney are done with my consent and have the same validity and effect as if I were present and exercised the powers myself, and will inure to the benefit of and bind me, my estate, my heirs, successors, assigns, and personal representatives. The authority of my health care agent pursuant to this power of attorney is superior to and binding on my family, relatives, friends, and others.

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**8. Miscellaneous Provisions.**

A. Revocation of Prior Powers of Attorney. I revoke any prior health care powers of attorney. The preceding sentence is not intended to revoke any general powers of attorney, some of the provisions of which may relate to health care; however, this power of attorney takes precedence over any health care provisions in any valid general power of attorney I have not revoked.

B. Jurisdiction, Severability, and Durability. This health care power of attorney is intended to be valid in any jurisdiction in which it is presented. The powers delegated under this power of attorney are severable, so that the invalidity of one or more powers does not affect any others. This power of attorney will not be affected or revoked by my incapacity or mental incompetence.

C. Health Care Agent Not Liable. My health care agent and my health care agent's estate, heirs, successors, and assigns are hereby released and forever discharged by me, my estate, my heirs, successors, assigns, and personal representatives from all liability and from all claims or demands of all kinds arising out of my health care agent's acts or omissions, except for my health care agent's willful misconduct or gross negligence.

D. No Civil or Criminal Liability. No act or omission of my health care agent, or of any other person, entity, institution, or facility acting in good faith in reliance on the authority of my health care agent pursuant to this health care power of attorney will be considered suicide, the cause of my death for any civil or criminal purposes, unprofessional conduct, or lack of professional competence. Any person, entity, institution, or facility against whom criminal or civil liability is asserted because of conduct authorized by this health care power of attorney may interpose this document as a defense.

E. Reimbursement. My health care agent is entitled to reimbursement for all reasonable expenses incurred as a result of carrying out any provision of this directive.

F. 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

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authority, my health care agent shall constitute my "personal representative" as defined by HIPAA.

On 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 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.

## HEALTHCARE DIRECTIVE/LIVING WILL

**1. Declaration.**

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 health care directives and living wills previously made by me.

**[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 long as reasonably possible 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

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systems and direct my attending physician to withhold or 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 my pregnancy.

B. I wish to receive treatment for comfort or to alleviate pain except as stated below:

If they are addictive.

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

C. I further direct that: Sample.

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

**2. Organ Donation.**
To the extent I have not already made valid and enforceable arrangements during my lifetime that have not been revoked, I wish to: Donate any needed organs or parts. I wish to donate for anatomical study/medical purposes if needed.

**3. General Provisions.**

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

B. 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.

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C. 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 will indemnify and hold them harmless.

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**PRINCIPAL'S SIGNATURE**

By signing here, I indicate that I am mentally alert and competent, fully informed as to the contents of this document, and understand the full import of this grant of powers to my health care agent.

This the _____ day of _____, 20____.

_____
Signature of Jane Doe

100 Main Street
[CITY], North Carolina [ZIP]

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## WITNESS DECLARATION

Each of the undersigned hereby states that: the principal, Jane Doe, being of sound mind, signed (or directed another to sign on the principal's behalf) the foregoing health care power of attorney in my presence, and that I am not related to the principal by blood or marriage, and I would not be entitled to any portion of the estate of the principal under any existing will or codicil of the principal or as an heir under the Intestate Succession Act, if the principal died on this date without a will. I also state that I am not the principal's attending physician or a licensed health care provider or mental health treatment provider who is: (1) an employee of the principal's attending physician or mental health treatment provider; (2) an employee of the health facility in which the principal is a patient; or (3) an employee of a nursing home or any adult care home where the principal resides. Each of the undersigned further states that: I do not have any claim against the principal or the estate of the principal.

Date:_____

Signature:_____

Print Name:_____

Address:_____

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Date:_____

Signature:_____

Print Name:_____

Address:_____

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**ACKNOWLEDGEMENT OF NOTARY PUBLIC**

State of North Carolina
County of [COUNTY]

Sworn to (or affirmed) and subscribed before me this day by Jane Doe, and _____, and _____ as witnesses.

Date: _____

_____
*Signature of Notary Public*

*(Official Seal)*

_____, Notary Public
*Print Name of Notary Public*

My commission expires:

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