TENNESSEE ADVANCE HEALTH CARE DIRECTIVE
(ADVANCE CARE PLAN)

OF

Jane Doe

I, Jane Doe, hereby give these advance instructions on how I want to be treated by my doctors and other health care providers when I can no longer make those treatment decisions myself. I revoke and make null and void any and all other health care directives, living wills, and health care powers of attorney previously made by me.

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

Agent: I want the following person to make health care decisions for me:

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

Alternate Agent: If the person named above is unable or unwilling to make health care decisions for me, I appoint as alternate:

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

legalzoom.com SAMPLE

_____
(Initial)

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

Quality of Life:

I want my doctors to help me maintain an acceptable quality of life including adequate pain management. A quality of life that is unacceptable to me means when I have any of the following conditions:

- **Permanent Unconscious Condition:** I become totally unaware of people or surroundings with little chance of ever waking up from the coma.

- **Terminal Condition:** I have a terminal condition and my attending physician has determined there is no reasonable medical expectation of recovery and which, as a medical probability, will result in my death, regardless of the use or discontinuance of medical treatment implemented for the purpose of sustaining life, or the life process.

- **End-Stage Illnesses:** I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that does not respond anymore to treatment; chronic and/or damaged heart and lungs, where oxygen needed most of the time and activities are limited due to the feeling of suffocation.

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

Treatment:

If my quality of life becomes unacceptable to me and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows**.**

- I DO NOT want CPR (Cardiopulmonary Resuscitation) described as follows**:** To make the heart beat again and restore breathing after it has stopped. Usually this involves electric shock, chest compressions, and breathing assistance.

- I DO NOT want life support / other artificial support described as follows: Continuous use of breathing machine, medications, and other equipment that helps the lungs, heart, kidneys and other organs to continue to work.

legalzoom.com SAMPLE

_____
(Initial)

- I DO NOT want the treatment of new conditions described as follows**:** Use of surgery, blood transfusions, or antibiotics that will deal with a new condition but will not help the main illness.

- I DO NOT want tube feeding/IV fluids described as follows**:** Use of tubes to deliver food and water to patient's stomach or use of IV fluids into a vein which would include artificially delivered nutrition and hydration.

Other instructions:

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

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

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

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

- The authority of my agent is limited as follows: Sample.

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

- I do not authorize my agent to direct the disposition of my remains. It is my desire that my remains be treated as follows: Sample. I further direct that: Sample.

- I do not authorize my agent to consent to an autopsy of my remains.

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

- I further direct that: [FURTHER DIRECTIVES].

In the absence of my ability to give directions regarding my medical care, it is my intention that this declaration shall be honored by my family and physician as the final expression of my legal right to refuse medical care and accept the consequences of such refusal.

legalzoom.com® SAMPLE

_____
(Initial)

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

Organ Donation:

Upon my death, I wish to make the following anatomical gift: Any and all organs/tissues.

I do direct my attending physician, if I have been determined dead according to Tennessee Code Annotated, § 68-3-501(b), to maintain me on artificial support systems only for the period of time required to maintain the viability of and to remove such organs and/or tissues.

My anatomical gift shall be used for the following purposes: Medical purposes only, education, and research.

General Provisions:

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.

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.

LegalZoom.com SAMPLE

_____
(Initial)

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.

SIGNATURES

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration. I have executed this document on the date below

Signature: _____ DATE: _____
(Signature of Jane Doe)

[ADDRESS]
[CITY], [STATE] [ZIP]

legalzoom.com
SAMPLE

_____
(Initial)

WITNESS DECLARATIONS

We, the subscribing witnesses hereto, are personally acquainted with and subscribe our names hereto at the request of the declarant, an adult, whom we believe to be of sound mind, fully aware of the action taken herein and its possible consequence.

We, the undersigned witnesses, further declare that we are not related to the declarant by blood or marriage; that we are not entitled to any portion of the estate of the declarant upon the declarant's decease under any will or codicil thereto presently existing or by operation of law then existing; that we are not the attending physician, an employee of the attending physician or a health facility in which the declarant is a patient; and that we are not persons who, at the present time, have a claim against any portion of the estate of the declarant upon the declarant's death.

We are also not named the declarant's health care representative.

Date: _____

Signature:_____

Print Name:_____

Address:_____

_____

Date: _____

Signature:_____

Print Name:_____

Address:_____

_____

legalzoom.com
SAMPLE

_____
(Initial)