CALIFORNIA ADVANCE HEALTH CARE DIRECTIVE

(LIVING WILL / POWER OF ATTORNEY FOR HEALTH CARE)

OF

Jane Doe

(California Probate Code Section 4701)

Explanation

You have the right to give instructions about your own health care. You also have the right to name someone else to make health care decisions for you. This document lets you do either or both of these things. It also lets you express your wishes regarding donation of organs. If you use this document, you may complete or modify all or any part of it. You are free to use a different document.

Part 1 of this document is a power of attorney for health care. Part 1 lets you name another individual as agent to make health care decisions for you if you become incapable of making your own decisions. You may also name an alternate agent to act for you if your first choice is not willing, able, or reasonably available to make decisions for you. (Your agent may not be an operator or employee of a community care facility or a residential care facility where you are receiving care, or your supervising health care provider or employee of the health care institution where you are receiving care, unless your agent is related to you or is a coworker.)

Unless the document you sign limits the authority of your agent, your agent may make all health care decisions for you. This document has a place for you to limit the authority of your agent. You need not limit the authority of your agent if you wish to rely on your agent for all health care decisions that may have to be made. If you choose not to limit the authority of your agent, your agent will have the right to:

(a) Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition.

(b) Select or discharge health care providers and institutions.
(c) Approve or disapprove diagnostic tests, surgical procedures, and programs of medication.

(d) Direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care, including cardiopulmonary resuscitation.

(e) Make anatomical gifts, authorize an autopsy, and direct disposition of remains.

Part 2 of this document lets you give specific instructions about any aspect of your health care, whether or not you appoint an agent. Choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive, as well as the provision of pain relief. Space is also provided for you to add to the choices you have made or for you to write out any additional wishes.

Part 3 of this document lets you express your intentions regarding the donation of your bodily organs and tissues following your death.

After completing this document, sign and date the document at the end. The document must be signed by two qualified witnesses or acknowledged before a notary public. Give a copy of the signed and completed document to your physician, to any other health care providers you may have, to any health care institution at which you are receiving care, and to any health care agents you have named. You should talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take the responsibility.

You have the right to revoke this advance health care directive or replace this document at any time.
PART 1

POWER OF ATTORNEY FOR HEALTH CARE

(1.1) DESIGNATION OF AGENT: I designate the following individual as my agent ("agent") to make health care decisions for me:

Name: Jane Doe  
Relation: Spouse  
Address: 123 Main Street  
Sacramento, California 11111  
Phone: (555) 555-5555  
Alt. Phone: (444) 444-4444  
Email: jdoe@LegalZoom.com

If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health care decision for me, I designate as my alternate agent:

Name: Ann Doe  
Relation: Sister  
Address: 500 Main Street  
Sacramento, California 11111  
Phone: (222) 222-2222  
Alt. Phone: (444) 444-4444  
Email: adoe@LegalZoom.com

(1.2) AGENT'S AUTHORITY: My agent is authorized to make all health care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care to keep me alive, except as I state here: SAMPLE.

(1.3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent’s authority becomes effective when my primary physician and another physician determine that I am unable to make my own health care decisions.

(1.4) AGENT’S OBLIGATION: My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in this document, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.
(1.5) AGENT’S POSTDEATH AUTHORITY: My agent is authorized to make anatomical gifts, authorized to consent to an autopsy, and authorized to direct disposition of my remains, except as I state specifically otherwise in this document.

(1.6) NOMINATION OF CONSERVATOR: If a conservator of my person needs to be appointed for me by a court, I nominate the agent designated in this document. If that agent is not willing, able, or reasonably available to act as conservator, I nominate the alternate agents whom I have named, in the order designated.
PART 2

INSTRUCTIONS FOR HEALTH CARE

(2.1) END-OF-LIFE DECISIONS: I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice below:

Choice To Prolong Life: I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

Choice Not To Prolong Life: I do not want my life to be prolonged if:

- I have an incurable and irreversible condition that will result in my death within a relatively short time.

- I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness.

- The likely risks and burdens of treatment would outweigh the expected benefits.

If I have the condition stated above, it is my preference to not receive artificially administered nutrition and hydration (food and fluids).

I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death except as follows: This section would include instructions about pain medication.

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

(2.2) OTHER WISHES: I direct that: This space is for additional instructions about your health care.
[This section varies depending upon your choices regarding organ donation.]

PART 3

DONATION OF ORGANS AT DEATH

(3.1) Upon my death: I give any needed organs, tissues, or parts.

My gift is for the following purposes: Transplant, Therapy, Research, Education.
PART 4

(4.1) 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 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.

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

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.

A copy of this document has the same effect as the original.
(4.2) SIGNATURE: I sign this document on the date below:

____________________________________
Signature of Jane Doe

Dated: _______________________, 20___

123 Main Street
Sacramento, California 11111
(4.3) STATEMENT OF WITNESSES: I declare under penalty of perjury under the laws of California: (1) that the individual who signed or acknowledged this advance health care directive is personally known to me, or that the individual’s identity was proven to me by convincing evidence; (2) that the individual signed or acknowledged this advance directive in my presence; (3) that the individual appears to be of sound mind and under no duress, fraud, or undue influence; (4) that I am not a person appointed as agent by this advance directive; and (5) that I am not the individual’s health care provider, an employee of the individual’s health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility for the elderly, nor an employee of an operator of a residential care facility for the elderly.

Signature: __________________________

Print Name: __________________________

Address: __________________________

(4.4) ADDITIONAL STATEMENT OF WITNESSES: At least one of the above witnesses must also sign the following declaration:

I further declare under penalty of perjury under the laws of California that I am not related to the individual executing this advance health care directive by blood, marriage, or adoption, and to the best of my knowledge, I am not entitled to any part of the individual’s estate upon his or her death under a will now existing or by operation of law.

Signature: __________________________

Print Name: __________________________
PART 5

SPECIAL WITNESS REQUIREMENT

STATEMENT OF PATIENT ADVOCATE OR OMBUDSMAN

I declare under penalty of perjury under the laws of California that I am a patient advocate or ombudsman as designated by the State Department of Aging and that I am serving as a witness as required by Section 4675 of the Probate Code.

Date: ________________________________
Signature: ____________________________
Print Name: __________________________
Address: ______________________________

* This page is signed and witnessed only if you (the person appointing an agent and/or giving health care instructions) are living in a skilled nursing facility when you sign the advance health care directive.
These are sample documents for the State of California. Actual content differs by state and may vary based on your answers to the LegalZoom questionnaire.

LegalZoom grants you permission to view and print these sample documents for your personal, informational, and non-commercial use. They may not be reproduced or sold for any purposes. Your answers to the LegalZoom questionnaire have not been applied to these sample documents so they are not fit for use.