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## **WISCONSIN HEALTHCARE DOCUMENTS**

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## **ENCLOSED DOCUMENTS**

### **1. Health Care Proxy**

A Health Care Proxy is an advance directive that lets you choose a person (or more than one person) you trust to make medical decisions for you if you can't speak for yourself. Depending on your state, a Health Care Proxy may be referred to as a Healthcare Power of Attorney, Medical Power of Attorney, Healthcare Agent, Healthcare Surrogate, Healthcare Representative, or Healthcare Attorney-in-fact.

### **2. Living Will**

A Living Will is an advance directive that lets you express the kinds of medical care you do or do not want to receive at the end of life. It's important to make sure your preferences are known to 1) make sure your wishes are honored and 2) reduce conflict and guilt among your loved ones if tough decisions need to be made someday.

### **3. HIPAA Release**

This document allows you to designate specific people that can obtain necessary information about your medical condition. This is especially important in the event of an emergency. Unless these individuals are next of kin and able to be present in the medical facility, doctors are unlikely to be able to update them with detailed information about your condition — especially over the phone.

## **Instructions to Complete the Power of Attorney for Health Care Form**

**Definitions.** ‘Department’ means the Department of Health Services. ‘Health Care’ means any care, treatment, service, or procedure to maintain, diagnose, or treat an individual’s physical or mental condition. ‘Health care decision’ means an informed decision in the exercise of the right to accept, maintain, discontinue, or refuse health care. ‘Health care facility’ means a facility, as defined in State Statute 647.01(4), or any hospital, nursing home, community-based residential facility, county home, county infirmary, county hospital, county mental health center, tuberculosis sanatorium or other place licensed or approved by the department under State Statutes 49.70, 49.71, 49.72, 50.02, 50.03, 50.35, 51.08, 51.09, 58.06, 252.073 or 252.076 or a facility under s. 45.365, 51.05, 51.06, 233.40, 233.41, 233.42 or 252.10. ‘Health care provider’ means a nurse licensed or permitted under State Statute Chapter 441, a chiropractor licensed under Chapter 446, a dentist licensed under Chapter 447, a physician, podiatrist or physical therapist licensed or an occupational therapist or occupational therapy assistant certified under Chapter 448, a person practicing Christian Science treatment, an optometrist licensed under Chapter 449, a psychologist licensed under Chapter 455, a partnership thereof, a corporation thereof that provides health care services, an operational cooperative sickness care plan organized under State Statute 185.981 to 185.985 that directly provides services through salaried employees in its own facility, or a home health agency, as defined in State Statute 50.49 (1) (a). ‘Incapacity’ means the inability to receive and evaluate information effectively or to communicate decisions to such an extent that the individual lacks the capacity to manage his or her health care decisions. ‘Feeding tube’ means a medical tube through which nutrition or hydration is administered into the vein, stomach, nose, mouth or other body opening of the declarant.

**Who may sign a Power of Attorney for Health Care?** An individual who is of sound mind and has attained age 18 may voluntarily execute a Power of Attorney for Health Care. An individual for whom an adjudication of incompetence and appointment of a guardian of the person is in effect under State Statute Chapter 880 is presumed not to be of sound mind.

**Procedures for signing a Power of Attorney for Health Care.** The principal (person creating the Power of Attorney for Health Care) and the witnesses all must sign the form at the same time.

**When does it take effect?** Unless otherwise specified in the Power of Attorney for Health Care instrument (form), an individual’s Power of Attorney for Health Care takes effect upon a finding of incapacity by 2 physicians, as defined in State Statute 448.01 (5), or one physician and one licensed psychologist, as defined in State Statute.455.01 (4), who personally examine the principal and sign a statement specifying that the principal has incapacity. Mere old age, eccentricity, or physical disability, either singly or together, is insufficient to make a finding of incapacity. Neither of the individuals who make a finding of incapacity may be a relative of the principal or have knowledge that he or she is entitled to or has a claim on any portion of the principal’s estate. A copy of the statement, if made, shall be appended to the Power of Attorney for Health Care instrument.

**Revocation.** A principal may revoke his or her Power of Attorney for Health Care and invalidate the Power of Attorney for Health Care instrument at any time by doing any of the following: canceling, defacing, obliterating, burning, tearing or otherwise destroying the Power of Attorney for Health Care instrument or directing another in the presence of the principal to so destroy the Power of Attorney for Health Care instrument; executing a statement, in writing, that is signed and dated by the principal, expressing the principal’s intent to revoke the Power of Attorney for Health Care; verbally expressing the principal’s intent to revoke the Power of Attorney for Health Care in the presence of 2 witnesses; or, executing a subsequent Power of Attorney for Health Care instrument. The principal’s health care provider shall, upon notification of revocation of the principal’s Power of Attorney for Health Care instrument, record in the principal’s medical record the time, date and place of the revocation and the time, date and place, if different, of the notification to the health care provider of the revocation.

**Immunities.** No health care facility or health care provider may be charged with a crime, held civilly liable, or charged with unprofessional conduct for any of the following: certifying incapacity under State Statute 155.05 (2), if the certification is made in good faith based on a thorough examination of the principal; failing to comply with a Power of Attorney for Health Care instrument or the decision of a health care agent, except that failure of a physician to comply constitutes unprofessional conduct if the physician refuses or fails to make a good faith attempt to transfer the principal to another physician who will comply; complying, in the absence of actual knowledge of a revocation, with the terms of a Power of Attorney for Health Care instrument that is in compliance with Chapter 155; complying with the decision of a health care agent that is made under a Power of Attorney for Health Care that is in compliance with Chapter 155; acting contrary to or failing to act on a revocation of a Power of Attorney for Health Care, unless the health care facility or health care provider has actual knowledge of the revocation; or, failing to obtain the health care decision for a principal from the principal's health care agent, if the health care facility or health care provider has made a reasonable attempt to contact the health care agent and obtain the decision but has been unable to do so. No health care agent may be charged with a crime or held civilly liable for making a decision in good faith under a Power of Attorney for Health Care instrument that is in compliance with Chapter 155. No health care agent who is not the spouse of the principal may be held personally liable for any goods or services purchased or contracted for under a Power of Attorney for Health Care instrument.

**General provisions.** The making of a health care decision on behalf of a principal under the principal's Power of Attorney for Health Care instrument does not, for any purpose, constitute suicide. No individual may be required to execute a Power of Attorney for Health Care as a condition for receipt of health care or admission to a health care facility. No insurer may refuse to pay for goods or services covered under a principal's insurance policy solely because the decision to use the goods or services was made by the principal's health care agent.

## **POWER OF ATTORNEY FOR HEALTH CARE DOCUMENT NOTICE TO PERSON MAKING THIS DOCUMENT**

**You have the right to make decisions about your health care. No health care may be given to you over your objection, and necessary health care may not be stopped or withheld if you object.**

**Because your health care providers in some cases may not have had the opportunity to establish a long term relationship with you, they are often unfamiliar with your beliefs and values and the details of your family relationships. This poses a problem if you become physically or mentally unable to make decisions about your health care.**

**In order to avoid this problem, you may sign this legal document to specify the person whom you want to make health care decisions for you if you are unable to make those decisions personally. That person is known as your health care agent. You should take some time to discuss your thoughts and beliefs about medical treatment with the person or persons whom you have specified. You may state in this document any types of health care that you do or do not desire, and you may limit the authority of your health care agent. If your health care agent is unaware of your desires with respect to a particular health care decision, he or she is required to determine what would be in your best interests in making the decision.**

**This is an important legal document. It gives your agent broad powers to make health care decisions for you. It revokes any prior power of attorney for health care that you may have made. If you wish to change your power of attorney for health care, you may revoke this document at any time by destroying it, by directing another person to destroy it in your presence, by signing a written and dated statement or by stating that it is revoked in the presence of two witnesses. If you revoke, you should notify your agent, health care provider, and any other person(s) to whom you have given a copy. If your agent is your spouse or your domestic partner and your marriage is annulled or you are divorced or your domestic partnership is terminated after signing this document, the document is invalid.**

**You may also use this document to make or refuse to make an anatomical gift upon your death. If you use this document to make or refuse to make an anatomical gift, this document revokes any prior record of gift that you may have made. You may revoke or change any anatomical gift that you make by this document by crossing out the anatomical gifts provision in this document.**

**Do not sign this document unless you clearly understand it. It is suggested that you keep the original of this document on file with your physician.**

**POWER OF ATTORNEY FOR HEALTH CARE**

Document made this \_\_\_\_\_ day of \_\_\_\_\_ (month), \_\_\_\_\_ (year).

**CREATION OF POWER OF ATTORNEY FOR HEALTH CARE**

I, \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(print name, address, and date of birth), being of sound mind, intend by this document to create a power of attorney for health care. My executing this power of attorney for health care is voluntary. Despite the creation of this power of attorney for health care, I expect to be fully informed about and allowed to participate in any health care decision for me, to the extent that I am able. For the purposes of this document, "health care decision" means an informed decision to accept, maintain, discontinue or refuse any care, treatment, service or procedure to maintain, diagnose or treat my physical or mental condition.

In addition, I may, by this document, specify my wishes with respect to making an anatomical gift upon my death.

**DESIGNATION OF HEALTH CARE AGENT**

If I am no longer able to make health care decisions for myself, due to my incapacity, I hereby designate \_\_\_\_\_  
\_\_\_\_\_

(print name, address and telephone number) to be my health care agent for the purpose of making health care decisions on my behalf. If he or she is ever unable or unwilling to do so, I hereby designate \_\_\_\_\_  
\_\_\_\_\_

(print name, address and telephone number) to be my alternate health care agent for the purpose of making health care decisions on my behalf. Neither my health care agent nor my alternate health care agent whom I have designated is my health care provider, an employee of my health care provider, an employee of a health care facility in which I am a patient or a spouse of any of those persons, unless he or she is also my relative. For purposes of this document, "incapacity" exists if 2 physicians or a physician and a psychologist who have personally examined me sign a statement that specifically expresses their opinion that I have a condition that means that I am unable to receive and evaluate information effectively or to communicate decisions to such an extent that I lack the capacity to manage my health care decisions.

A copy of that statement must be attached to this document.

### **GENERAL STATEMENT OF AUTHORITY GRANTED**

Unless I have specified otherwise in this document, if I ever have incapacity I instruct my health care provider to obtain the health care decision of my health care agent, if I need treatment, for all of my health care and treatment. I have discussed my desires thoroughly with my health care agent and believe that he or she understands my philosophy regarding the health care decisions I would make if I were able. I desire that my wishes be carried out through the authority given to my health care agent under this document.

If I am unable, due to my incapacity, to make a health care decision, my health care agent is instructed to make the health care decision for me, but my health care agent should try to discuss with me any specific proposed health care if I am able to communicate in any manner, including by blinking my eyes. If this communication cannot be made, my health care agent shall base his or her decision on any health care choices that I have expressed prior to the time of the decision. If I have not expressed a health care choice about the health care in question and communication cannot be made, my health care agent shall base his or her health care decision on what he or she believes to be in my best interest.

### **LIMITATIONS ON MENTAL HEALTH TREATMENT**

My health care agent may not admit or commit me on an inpatient basis to an institution for mental diseases, an intermediate care facility for the persons with mental retardation, a state treatment facility, or a treatment facility. My health care agent may not consent to experimental mental health research or psychosurgery, electroconvulsive treatment or drastic mental health treatment procedures for me.

### **ADMISSION TO NURSING HOMES OR COMMUNITY-BASED RESIDENTIAL FACILITIES**

My health care agent may admit me to a nursing home or community-based residential facility for short-term stays for recuperative care or respite care.

If I have checked "Yes" to the following, my health care agent may admit me for a purpose other than recuperative care or respite care, but if I have checked "No" to the following, my health care agent may not so admit me:

1. A nursing home -  Yes     No
  
2. A community-based residential facility -  Yes     No

If I have not checked either "Yes" or "No" immediately above, my health care agent may admit me only for short-term stays for recuperative care or respite care.

**PROVISION OF FEEDING TUBE**

If I have checked “Yes” to the following, my health care agent may have a feeding tube withheld or withdrawn from me, unless my physician has advised that, in his or her professional judgment, this will cause me pain or will reduce my comfort. If I have checked “No” to the following, my health care agent may not have a feeding tube withheld or withdrawn from me.

My health care agent may not have orally ingested nutrition or hydration withheld or withdrawn from me unless provision of the nutrition or hydration is medically contraindicated.

Withhold or withdraw a feeding tube -  Yes     No

If I have not checked either “Yes” or “No” immediately above, my health care agent may not have a feeding tube withdrawn from me.

**HEALTH CARE DECISIONS FOR PREGNANT WOMEN**

If I have checked “Yes” to the following, my health care agent may make health care decisions for me even if my agent knows I am pregnant. If I have checked “No” to the following, my health care agent may not make health care decisions for me if my health care agent knows I am pregnant.

Health care decision if I am pregnant -  Yes     No

If I have not checked either “Yes” or “No” immediately above, my health care agent may not make health care decisions for me if my health care agent knows I am pregnant.

**STATEMENT OF DESIRES, SPECIAL PROVISIONS OR LIMITATIONS**

In exercising authority under this document, my health care agent shall act consistently with my following stated desires, if any, and is subject to any special provisions or limitations that I specify. The following are any specific desires, provisions or limitations that I wish to state (add more items if needed):

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_

**INSPECTION AND DISCLOSURE OF INFORMATION  
RELATING TO MY PHYSICAL OR MENTAL HEALTH**

Subject to any limitations in this document, my health care agent has the authority to do all of the following:

- (a) Request, review and receive any information, oral or written, regarding my physical or mental health, including medical and hospital records.
- (b) Execute on my behalf any documents that may be required in order to obtain this information.
- (c) Consent to the disclosure of this information.



(The principal and the witnesses all must sign the document at the same time.)

**SIGNATURE OF PRINCIPAL**

(Person creating the Power of Attorney for Health Care)

Signature \_\_\_\_\_ Date \_\_\_\_\_

(The signing of this document by the principal revokes all previous powers of attorney for health care documents.)

**STATEMENT OF WITNESSES**

I know the principal personally and I believe him or her to be of sound mind and at least 18 years of age. I believe that his or her execution of this power of attorney for health care is voluntary. I am at least 18 years of age, am not related to the principal by blood, marriage, domestic partnership under Wisconsin Statutes chapter 770, or adoption, and am not directly financially responsible for the principal's health care. I am not a health care provider who is serving the principal at this time, an employe of the health care provider, other than a chaplain or a social worker, or an employe, other than a chaplain or a social worker, of an inpatient health care facility in which the declarant is a patient. I am not the principal's health care agent. To the best of my knowledge, I am not entitled to and do not have a claim on the principal's estate.

Witness Number 1

(Print) Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

Signature \_\_\_\_\_

Witness Number 2

(Print) Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

Signature \_\_\_\_\_

**STATEMENT OF HEALTH CARE AGENT AND ALTERNATE HEALTH CARE AGENT**

I understand that \_\_\_\_\_ (name of principal) has designated me to be his or her health care agent or alternate health care agent if he or she is ever found to have incapacity and unable to make health care decisions himself or herself. \_\_\_\_\_ (name of principal) has discussed his or her desires regarding health care decisions with me.

Agent's Signature \_\_\_\_\_

Address \_\_\_\_\_

Alternate's Signature \_\_\_\_\_

Address \_\_\_\_\_

Failure to execute a power of attorney for health care document under chapter 155 of the Wisconsin Statutes creates no presumption about the intent of any individual with regard to his or her health care decisions.

This power of attorney for health care is executed as provided in chapter 155 of the Wisconsin Statutes.

### ANATOMICAL GIFTS (optional)

Upon my death:

I wish to donate only the following organs or parts: \_\_\_\_\_

\_\_\_\_\_  
(specify the organs or parts).  
\_\_\_\_\_

I wish to donate any needed organ or part.

I wish to donate my body for anatomical study if needed.

I refuse to make an anatomical gift. (If this revokes a prior commitment that I have made to make an anatomical gift to a designated donee, I will attempt to notify the donee to which or to whom I agreed to donate.)

Failing to check any of the lines immediately above creates no presumption about my desire to make or refuse to make an anatomical gift.

Signature \_\_\_\_\_ Date \_\_\_\_\_



DIVISION OF PUBLIC HEALTH

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To Whom It May Concern:

Enclosed is the Declaration to Physicians (Living Will) form you requested. This form makes it possible for adults in Wisconsin to state their preferences for life-sustaining procedures and feeding tubes in the event the person is in a terminal condition or persistent vegetative state.

**Be sure to read both sides of the form carefully and understand it before you complete and sign it.**

The withholding or withdrawal of any medication, life-sustaining procedure or feeding tube may not be made if the attending physician advises that doing so will cause pain or reduce comfort, and the pain or discomfort cannot be alleviated through pain relief measures.

**Two witnesses are required.** Witnesses must be at least 18 years of age, not related to you by blood, marriage or adoption, and not directly financially responsible for your health care. Witnesses may not be persons who know they are entitled to or have a claim on any portion of your estate. A witness cannot be a health care provider who is serving you at the time the document is signed, an employee of the health care provider, other than a chaplain or a social worker, or an employee other than a chaplain or social worker of an inpatient health care facility in which you are a patient. Valid witnesses acting in good faith are immune from civil or criminal liability.

You should make relatives and friends aware that you have signed the document and the location where it is kept. A signed form may be kept in a safe, easily accessible place until needed. The document may be filed for safekeeping for a fee with the Register in Probate of your county of residence, but it is not required that it be filed. The fee for filing with the Register in Probate has been set by State Statute at \$8.00.

You are responsible for notifying your attending physician of the existence of the Declaration. An attending physician who is notified shall make the Declaration part of your medical records. A Declaration that is in its original form or is a legible photocopy or electronic facsimile copy is presumed to be valid.

If you have both a Declaration to Physicians and a Power of Attorney for Health Care, the provisions of a valid Power of Attorney for Health Care supersede any directly conflicting provisions of a valid Declaration to Physicians.

Up to four copies of the Declaration to Physicians are available free to anyone who sends a stamped, self-addressed, business-size envelope to: Living Will, Division of Public Health, P.O. Box 2659, Madison, Wisconsin 53701-2659. You may make additional copies of the enclosed blank form. The form is also available on the Department of Health Services Web page <http://dhs.wisconsin.gov/forms/DPHnum.asp>.

If you have questions about the availability of the Declaration to Physicians (Living Will) form or obtaining larger quantities of the form, you may contact the Division of Public Health at (608) 266-1251.

## **INSTRUCTIONS FOR DECLARATION TO PHYSICIANS FORM**

### Definitions

“Declaration” means a written, witnessed document voluntarily executed by the declarant under State Statute 154.03 (1), but is not limited in form or substance to that provided in State Statute 154.03 (2).

“Department” means the Department of Health Services.

“Feeding tube” means a medical tube through which nutrition or hydration is administered into the vein, stomach, nose, mouth or other body opening of a qualified patient.

“Terminal condition” means an incurable condition caused by injury or illness that reasonable medical judgment finds would cause death imminently, so that the application of life-sustaining procedures serves only to postpone the moment of death.

“Persistent vegetative state” means a condition that reasonable, medical judgment finds constitutes complete and irreversible loss of all the functions of the cerebral cortex and results in a complete, chronic and irreversible cessation of all cognitive functioning and consciousness and a complete lack of behavioral responses that indicate cognitive functioning, although autonomic functions continue.

“Qualified patient” means a declarant who has been diagnosed and certified in writing to be afflicted with a terminal condition or to be in a persistent vegetative state by two physicians, one of whom is the attending physician, who have personally examined the declarant.

“Attending physician” means a physician licensed under State Statute Chapter 448 who has primary responsibility for the treatment and care of the patient.

“Health care professional” means a person licensed, certified or registered under State Statutes Chapters 441, 448 or 455.

“Inpatient health care facility” has the meaning provided under State Statute 50.135 (1) and includes community-based residential facilities as defined in State Statute 50.01 (1g).

“Life-sustaining procedure” means any medical procedure or intervention that, in the judgment of the attending physician, would serve only to prolong the dying process but not avert death when applied to a qualified patient.

“Life-sustaining procedure” includes assistance in respiration, artificial maintenance of blood pressure and heart rate, blood transfusion, kidney dialysis and other similar procedures, but does not include (a) the alleviation of pain by administering medication or by performing an medical procedure; or (b) the provision of nutrition or hydration.

#### Procedures for signing Declarations

A Declaration must be signed by the declarant in the presence of two witnesses. If the declarant is physically unable to sign a Declaration, the Declaration must be signed in the declarant’s name by one of the witnesses or some other person at the declarant’s express direction and in his or her presence; such a proxy signing shall either take place or be acknowledged by the declarant in the presence of two witnesses.

#### Effect of Declaration

The desires of a qualified patient who is competent supersede the effect of the Declaration at all times. If a qualified patient is incompetent at the time of the decision to withhold or withdraw life-sustaining procedures or feeding tubes, a Declaration executed under this chapter is presumed to be valid.

#### Revocation of Declaration

A Declaration may be revoked at any time by the declarant by any of the following methods:

- 1) By being canceled, defaced, obliterated, burned, torn or otherwise destroyed by the declarant or by some person who is directed by the declarant and who acts in the presence of the declarant.
- 2) By a written revocation, signed and dated by the declarant expressing the intent to revoke.
- 3) By a verbal expression by the declarant of his or her intent to revoke the Declaration, but only if the declarant or a person acting on behalf of the declarant notifies the attending physician of the revocation.
- 4) By executing a subsequent Declaration.

The attending physician shall record in the declarant’s medical records the time, date and place of the revocation and time, date and place, if different, that he or she was notified of the revocation.

#### Liabilities

No physician, inpatient health care facility or health care professional acting under direction of a physician may be held criminally or civilly liable, or charged with unprofessional conduct of any of the following:

- 1) Participating in the withholding or withdrawal of life-sustaining procedures or feeding tubes under Chapter 154, subchapter II.
- 2) Failing to act upon a revocation unless the person or facility has actual knowledge of the revocation.
- 3) Failing to comply with a Declaration, except that failure by a physician to comply with a Declaration of a qualified patient constitutes unprofessional conduct if the physician refuses or fails to make a good faith attempt to transfer the patient to another physician who will comply with the Declaration.

**PLEASE BE SURE YOU READ THE FORM CAREFULLY AND UNDERSTAND IT  
BEFORE YOU COMPLETE AND SIGN IT**

**DECLARATION TO PHYSICIANS  
(WISCONSIN LIVING WILL)**

I, \_\_\_\_\_

being of sound mind, voluntarily state my desire that my dying not be prolonged under the circumstances specified in this document. Under those circumstances, I direct that I be permitted to die naturally. If I am unable to give directions regarding the use of life-sustaining procedures or feeding tubes, I intend that my family and physician honor this document as the final expression of my legal right to refuse medical or surgical treatment.

1. If I have a **TERMINAL CONDITION**, as determined by 2 physicians who have personally examined me, I do not want my dying to be artificially prolonged and I do not want life-sustaining procedures to be used. In addition, the following are my directions regarding the use of feeding tubes:

- YES, I want feeding tubes used if I have a terminal condition.
- NO, I do not want feeding tubes used if I have a terminal condition.

If you have not checked either box, feeding tubes will be used.

2. If I am in a **PERSISTENT VEGETATIVE STATE**, as determined by 2 physicians who have personally examined me, the following are my directions regarding the use of life-sustaining procedures:

- YES, I want life-sustaining procedures used if I am in a persistent vegetative state .
- NO, I do not want life-sustaining procedures used if I am in a persistent vegetative state.

If you have not checked either box, life-sustaining procedures will be used.

3. If I am in a **PERSISTENT VEGETATIVE STATE**, as determined by 2 physicians who have personally examined me, the following are my directions regarding the use of feeding tubes:

- YES, I want feeding tubes used if I am in a persistent vegetative state.
- NO, I do not want feeding tubes used if I am in a persistent vegetative state.

If you have not checked either box, feeding tubes will be used.

If you are interested in more information about the significant terms used in this document, see section 154.01 of the Wisconsin Statutes or the information accompanying this document.

**ATTENTION:** You and the 2 witnesses must sign the document at the same time.

**Signed** \_\_\_\_\_ **Date** \_\_\_\_\_

**Address** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

I believe that the person signing this document is of sound mind. I am an adult and am not related to the person signing this document by blood, marriage or adoption. I am not entitled to and do not have a claim on any portion of the person's estate and am not otherwise restricted by law from being a witness.

Witness **Signature** \_\_\_\_\_ **Date Signed** \_\_\_\_\_

**Print Name** \_\_\_\_\_

Witness **Signature** \_\_\_\_\_ **Date Signed** \_\_\_\_\_

**Print Name** \_\_\_\_\_

**DIRECTIVES TO ATTENDING PHYSICIAN**

1. This document authorizes the withholding or withdrawal of life-sustaining procedures or of feeding tubes when 2 physicians, one of whom is the attending physician, have personally examined and certified in writing that the patient has a terminal condition or is in a persistent vegetative state.

2. The choices in this document were made by a competent adult. Under the law, the patient's stated desires must be followed unless you believe that withholding or withdrawing life-sustaining procedures or feeding tubes would cause the patient pain or reduced comfort and that the pain or discomfort cannot be alleviated through pain relief measures. If the patient's stated desires are that life-sustaining procedures or feeding tubes be used, this directive must be followed.

3. If you feel that you cannot comply with this document, you must make a good faith attempt to transfer the patient to another physician who will comply. Refusal or failure to make a good faith attempt to do so constitutes unprofessional conduct.

4. If you know that the patient is pregnant, this document has no effect during her pregnancy.

\* \* \* \* \*

The person making this living will may use the following space to record the names of those individuals and health care providers to whom he or she has given copies of this document:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# HIPAA Release Form

Please complete all sections of this HIPAA release form. If any sections are left blank, this form will be invalid and it will not be possible for your health information to be shared as requested.

## Section I

I, \_\_\_\_\_, give my permission for \_\_\_\_\_ to share the information listed in Section II of this document with the person(s) or organization(s) I have specified in Section IV of this document.

## Section II – Health Information

I would like to give the above healthcare organization permission to:

Tick as appropriate

Disclose my complete health record including, but not limited to, diagnoses, lab test results, treatment, and billing records for all conditions.

Or

Disclose my complete health record except for the following information

- Mental health records
- Communicable diseases including, but not limited to, HIV and AIDS
- Alcohol/drug abuse treatment records
- Genetic information
- Other (Specify)

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Form of Disclosure:

- Electronic copy or access via a web-based portal
- Hard copy

## Section III – Reason for Disclosure

Please detail the reasons why information is being shared. If you are initiating the request for sharing information and do not wish to list the reasons for sharing, write 'at my request'.

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**Section IV – Who Can Receive My Health Information**

I give authorization for the health information detailed in section II of this document to be shared with the following individual(s) or organization(s)

Name: \_\_\_\_\_

Organization: \_\_\_\_\_

Address: \_\_\_\_\_

I understand that the person(s)/organization(s) listed above may not be covered by state/federal rules governing privacy and security of data and may be permitted to further share the information that is provided to them.

**Section V – Duration of Authorization**

This authorization to share my health information is valid:

Tick as appropriate

a) From \_\_\_\_\_ to \_\_\_\_\_

Or

b) All past, present, and future periods

Or

c) The date of the signature in section VI until the following event:

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I understand that I am permitted to revoke this authorization to share my health data at any time and can do so by submitting a request in writing to:

Name: \_\_\_\_\_

Organization: \_\_\_\_\_

Address: \_\_\_\_\_

I understand that:

- In the event that my information has already been shared by the time my authorization is revoked, it may be too late to cancel permission to share my health data.
- I understand that I do not need to give any further permission for the information detailed in Section II to be shared with the person(s) or organization(s) listed in section IV.



- I understand that the failure to sign/submit this authorization or the cancellation of this authorization will not prevent me from receiving any treatment or benefits I am entitled to receive, provided this information is not required to determine if I am eligible to receive those treatments or benefits or to pay for the services I receive.

**Section VI – Signature**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print your name: \_\_\_\_\_

If this form is being completed by a person with legal authority to act an individual's behalf, such as a parent or legal guardian of a minor or health care agent, please complete the following information:

Name of person completing this form: \_\_\_\_\_

Signature of person completing this form: \_\_\_\_\_

Describe below how this person has legal authority to sign this form:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



## CRITICAL STEP: SHARE YOUR COMPLETED DOCUMENTS

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**Your documents are only helpful if people know where to find them when they are needed.** It's also important to discuss the decisions outlined in your documents with anyone you designate to act on your behalf in a health emergency. Here's a quick guide to sharing your documents once they have been completed to satisfy the legal requirements for your state (where applicable).

### Who needs a copy of your documents?

- Anyone assigned a decision-making role in the documents
- A spouse or significant other
- A trusted family member or friend
- Any doctors you see on a regular basis
- Any hospital or facility in which you regularly receive care
- A lawyer and/or estate planner, if you have one

### Ways to share your documents

**Share with Cake!** Upload your documents to a free Cake account for safekeeping and secure sharing with your family. Create your free Cake account at [www.joincake.com/share-free](http://www.joincake.com/share-free)

**Or, print** and provide copies to everyone who needs one

### Finish your planning with Cake!

- Get a personalized checklist that guides you through each step
- Make healthcare, financial, funeral, and legacy decisions
- Create, upload, and print *all* your end-of-life documents
- Share 24/7 access with anyone that has an email address\*

**Create your free Cake account:** [www.joincake.com/share-free](http://www.joincake.com/share-free)

*\* Some healthcare providers may require a paper copy of your documents to be able to enter them into their records.*