

Finishing Well 2025

Running the Laps In the Medical Arena

Handouts:

- Patient Bill of Rights
- GA Advance Directives
- HIPPA Release Form

Patient Bill of Rights and Responsibilities

BUREAU OF MEDICAL SERVICES

[↓ DOWNLOAD PATIENT BILL OF RIGHTS AND RESPONSIBILITIES](#) [241 KB]

The U.S. Department of State's Bureau of Medical Services (MED) recognizes that the health and well-being of patients depends on a collaborative effort between patients and MED's medical service providers. Patients have both rights and responsibilities when they interact with MED staff at post health units, which are described below.

As a patient, you have the right to:

Timely access to medical care.

Be treated with dignity and respect by each MED health unit staff member.

Medical care that is free from discrimination on the basis of age, sex*, race, ethnicity, national origin, language, disease, disability, or religion.

Easy-to-understand information about your diagnosis and treatment options from your MED medical service provider.

Ask your MED medical service provider questions so that you can make informed decisions about your health.

Request the professional qualifications of the primary MED medical service provider rendering care.

Communicate confidentially with your MED medical service provider.

Privacy and confidentiality as outlined in the Notice of Privacy Practices (available at your health unit).

Withdraw your consent, delay, or otherwise refuse examination, intervention, or treatment.

Continuity of care – if for any reason you decide to seek care elsewhere, your MED medical service provider will work to coordinate your care in accordance with your wishes.

Review and request amendments to your medical records.

Provide confidential feedback about any matter that occurs in MED Health Units by available means, including the MED Feedback Survey, accessible at www.bit.ly/MEDFeedbackSurvey.

As a patient, you have a responsibility to:

Conduct all your interactions with MED Health Unit staff members, other patients, and visitors in a respectful and polite manner. Verbal or physical intimidation, violence, or the threat of violence towards anyone will not be tolerated and will be reported to the appropriate authorities.

Be honest and forthcoming with your MED medical service provider about the symptoms you are experiencing.

Provide as complete a medical history as you can, which includes details and information about past illnesses, medications, hospitalizations, and other matters related to current health.

Cooperate with agreed-upon treatment plans.

Coordinate routine medical care and delivery of needed medications if you accept an assignment at a post where such care or medication may not be available.

Fulfill financial responsibilities that are incurred when seeking medical care on the local economy.

Understand that the Health Unit operates in a manner intended to protect patient safety, safeguard confidentiality, and reduce the risk of medical errors. Health Units adhere to established business hours, observe standard operating procedures, and provide care consistent with health unit capabilities and available resources.

* As defined by current U.S. Equal Employment Opportunity Commission policy

**GEORGIA
ADVANCE
DIRECTIVE
FOR
HEALTH
CARE**

Revised March 2016

Purpose:

In recognizing the right of individuals to (1) control all aspects of his or her personal care and medical treatment, (2) insist upon medical treatment, (3) decline medical treatment, or (4) direct that medical treatment be withdrawn, the General Assembly has in the past, provided statutory forms for both the living will and durable power of attorney for health care. To help reduce confusion, inconsistency, out-of-date terminology, and confusing and inconsistent requirements for execution, and to follow the trend set by other states to combine the concepts of the living will and health care agency into a single legal document, the efforts of a significant number of individuals representing the academic, medical, legislative, and legal communities, state officials, ethics scholars, and advocacy groups produced the development of a consolidated advance directive for health care. This newly created form using understandable and everyday language is meant to encourage more citizens of Georgia to voluntarily execute advance directives for health care to make their wishes more clearly known.

The General Assembly takes note that the clear expression of individual decisions regarding health care, whether made by the individual or an agent appointed by the individual, is of critical importance not only to citizens but also to the health care and legal communities, third parties, and families. In furtherance of these purposes, the General Assembly enacted a new Chapter 32 of Title 31. This Chapter sets forth general principles governing the expression of decisions regarding health care and the appointment of a health care agent, as well as a form of advance directive for health care.

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INSTRUCTIONS

The effect of the Georgia Advance Directive for Health Care Act on the Georgia Living Will and Georgia Durable Power of Attorney for Health Care Laws.

Georgia's laws on advance directives changed significantly on July 1, 2007.

- ☞ The Georgia Advance Directive for Health Care Act replaced the Georgia Living Will as the new Chapter 32 of Title 31 of the Official Code of Georgia.
- ☞ Chapter 36 of Title 31 of the Official Code of Georgia creating the Durable Power of Attorney for HealthCare was repealed and that chapter reserved, meaning that for now, no law will be found in Chapter 36, but the space and the Chapter number will be reserved for future use.
- ☞ The Living Will and Durable Power of Attorney for Health Care will no longer be available as options for advance directives in Georgia.
- ☞ Validly executed Living Wills created between **March 28, 1986 and June 30, 2007** remain valid until revoked.
- ☞ Validly executed Durable Powers of Attorney for Health Care created before **June 30, 2007** remain valid until revoked.

To know if your current Living Will and/or Durable Power of Attorney for Health Care is valid, find a copy of the old code sections to confirm the witnessing requirements or consult an attorney who can compare it with the law in effect prior to July 1, 2007.

If one chooses to complete a Georgia Advance Directive for Health Care, it will replace any other advance directive for health care, durable power of attorney for health care, health care proxy, or living will that currently is in place. One may choose not to complete this form and his/her current Living Will and/or Durable Power of Attorney for Health Care form, if valid now, remains valid.

A Georgia Advance Directive for Health Care is Never Required

Definitions:

(1) 'Advance directive for health care' means a written document voluntarily executed by a declarant in accordance with the requirements of Code Section 31-32-5.

(2) 'Attending physician' means the physician who has primary responsibility at the time of reference for the treatment and care of the declarant.

(3) 'Declarant' means a person who has executed an advance directive for health care authorized by this chapter.

(4) 'Durable power of attorney for health care' means a written document voluntarily executed by an individual creating a health care agency in accordance with Chapter 36 of this title; as such chapter existed on and before June 30, 2007.

(5) 'Health care' means any care, treatment, service, or procedure to maintain, diagnose, treat, or provide for a declarant's physical or mental health or personal care.

(6) 'Health care agent' means a person appointed by a declarant to act for and on behalf of the declarant to make decisions related to consent, refusal, or withdrawal of any type of health care and decisions related to autopsy,

anatomical gifts, and final disposition of a declarant's body when a declarant is unable or chooses not to make health care decisions for himself or herself. The term 'health care agent' shall include any back-up or successor agent appointed by the declarant.

(7) 'Health care facility' means a hospital, skilled nursing facility, hospice, institution, home, residential or nursing facility, treatment facility, and any other facility or service which has a valid permit or provisional permit issued under Chapter 7 of this title or which is licensed, accredited, or approved under the laws of any state, and includes hospitals operated by the United States government or by any state or subdivision thereof.

(8) 'Health care provider' means the attending physician and any other person administering health care to the declarant at the time of reference who is licensed, certified, or otherwise authorized or permitted by law to administer health care in the ordinary course of business or the practice of a profession, including any person employed by or acting for any such authorized person.

(9) 'Life-sustaining procedures' means medications, machines, or other medical procedures or interventions which, when applied to a declarant in a terminal condition or in a state of permanent unconsciousness, could in reasonable medical judgment keep the declarant alive but cannot cure the declarant and where, in the judgment of the attending physician and a second physician, death will occur without such procedures or interventions. The term 'life-sustaining procedures' shall not include the provision of nourishment or hydration but a declarant may direct the withholding or withdrawal of the provision of nourishment or hydration in an advance directive for health care. The term 'life-sustaining procedures' shall not include the administration of medication to alleviate pain or the performance of any medical procedure deemed necessary to alleviate pain.

(10) 'Living will' means a written document voluntarily executed by an individual directing the withholding or withdrawal of life-sustaining procedures when an individual is in a terminal condition, coma, or persistent vegetative state in accordance with this chapter, as such chapter existed on and before June 30, 2007.

(11) 'Physician' means a person lawfully licensed in this state to practice medicine and surgery pursuant to Article 2 of Chapter 34 of Title 43; and if the declarant is receiving health care in another state, a person lawfully licensed in such state.

(12) 'Provision of nourishment or hydration' means the provision of nutrition or fluids by tube or other medical means.

(13) 'State of permanent unconsciousness' means an incurable or irreversible condition in which the declarant is not aware of himself or herself or his or her environment and in which the declarant is showing no behavioral response to his or her environment.

(14) 'Terminal condition' means an incurable or irreversible condition which would result in the declarant's death in a relatively short period of time.

Certification of a terminal condition or state of permanent unconsciousness

Before any action can be taken to withdraw or withhold life sustaining procedures or to withdraw or withhold nourishment or hydration for a declarant in a state of permanent unconsciousness or is in a terminal condition, that condition **must** be certified in writing. The attending physician **and** one other physician **must** personally examine the declarant and certify in writing based upon the declarant's condition found during the course of their examination and in accordance with current accepted

medical standards that the declarant does meet the criteria for terminal condition or state of permanent unconsciousness as defined above.

No limitation on the use of other advance directives forms

Using this form of advance directive for health care is completely optional. Other forms of advance directives for health care that substantially comply with this form may be used in Georgia.

This includes using forms from other states.

The difference between this advance directive form and the Living Will and Durable Power of Attorney for Health Care

The Georgia Advance Directive for Health Care is an attempt to combine the best features of the Living Will and Durable Power of Attorney for Health Care into one written document. An effort has also been made to make the execution (signing and witnessing) of this document easier and more convenient. The effect of this new document still does not constitute suicide, physician assisted suicide, homicide or euthanasia. Completing one has no affect on insurance, annuities or anything else contingent on the life or death of the person making the advance directive (hereafter, “the declarant”).

Three parts of the Georgia Advance Directive for Health Care

Part One: allows an agent to be appointed to carry out health care decisions (formerly the Durable Power of Attorney for Health Care)

Part Two: allows choices about withholding or withdrawing life support and accepting or refusing nutrition and/or hydration (formerly the Living Will)

Part Three: allows one to nominate someone to be appointed as Guardian if a court determines that a guardian is necessary.

Requirements for the person making an advance directive for health care

- ◆ Must be of sound mind
- ◆ Must be 18 years of age or older Or An emancipated minor

Executing the advance directive for health care

- 1) the declarant must sign or expressly direct someone else do it for him/her
- 2) two witnesses required, who are
 - of sound mind
 - 18 years of age or older
 - Witnesses do not have to see the declarant sign
 - Witnesses do not have to see each other sign the advance directive
- 3) the declarant must see both witnesses sign
- 4) Restriction on witnesses
 - Not the health care agent

- Not knowingly be in line to inherit anything from or benefit from the death of the declarant
- Not directly involved in the health care of the declarant
- Only one of the two witnesses can be an employee, agent or on the medical staff of the health care facility where the declarant is receiving his/her health care

Restrictions on the health care agent

A physician or health care provider directly involved in the care of the declarant may not serve as health care agent.

Duty of the health care agent to act

- ♦ A health care agent has no duty to act, even if named.
- ♦ If the health care agent does choose to act, s/he must not make decisions that are different or that contradict the decisions of the declarant.
- ♦ All of the health care agent's actions must be consistent with the intentions and desires of the declarant.
- ♦ If those intentions and desires are not clear, the health care agent's actions must be in the best interests of the declarant considering all of the benefits, burdens, risks and treatments options.

Authorized responsibilities/duties of the health care agent related to the necessary care of the declarant

- 1) Consent to, authorize, withdraw consent from, refuse, withhold, any and all types of medical/surgical care, treatment, programs and/or procedures
- 2) Sign and deliver all instruments (documents)

- 3) Negotiate and enter into all agreements and contracts binding the declarant
- 4) Accompany him/her in an ambulance or air ambulance
- 5) Admit to or discharge the declarant from any health care facility
- 6) Visit and consult with the declarant as necessary
- 7) Examine, copy and consent to disclosure of all the declarant's medical records deemed relevant
- 8) Do all other acts reasonably necessary and carry out duties and responsibilities in person or through those employed by the health care agent; **this does not include delegating the authority to make health care decisions**
- 9) Consent to an anatomical gift of the declarant's body, in whole or part, an autopsy and direct the final disposition of declarant's remains, including funeral arrangements, burial, or cremation (*Note: the law states that the agent can bind the declarant to pay but does not expressly mention binding the estate of the declarant. It may be a good idea to make all arrangements prior to the death of the declarant.*)

Prohibited actions by the health care agent

The health care agent may not consent to psychosurgery, sterilization, or involuntary hospitalization or treatment under the Mental Health Code, Title 37.

When the attending physician, health care provider and/or health care facility refuse to honor the advance directive for health care

The law states:

For health care decisions with which health care providers are unwilling to comply, after this decision is communicated with the agent, the agent is responsible for arranging for the declarant's transfer to another health care provider. [O.C.G.A. §31-32-8(2)] This section of the law does not expressly include life-sustaining procedures, nourishment or hydration in "health care decisions."

For a declarant's decision to withhold or withdraw life-sustaining procedures or withhold or withdraw the provision of nourishment or hydration, attending physicians who fail or refuse to comply are responsible for making a good faith attempt to effect the transfer of the declarant to *another physician* who will comply or must permit the agent, next of kin or legal guardian to obtain another physician who will comply. [O.C.G.A. §31-32-9 (d) (1-2)]

If it is the health care facility that refuses to comply with the declarant's decision to withhold or withdraw life-sustaining procedures or nutrition or hydration, the law does not expressly state whose responsibility it is to ensure the declarant is transferred to another health care facility.

Revoking this advance directive for health care

The Georgia Advance Directive for Health Care may be revoked at any time, regardless of the declarant's mental state or competency. **It remains effective even if a Guardian is appointed for the declarant unless a court specifically orders otherwise.**

Revocation can occur in any of the following ways:

- ◆ By completing a new advance directive for health care
- ◆ By burning, tearing up, or otherwise destroying the existing advance directive for health care
- ◆ By writing a clear statement expressing the intent to revoke the advance directive for health care
- ◆ By orally expressing the intent to revoke the advance directive for health care in the presence of a witness 18 years of age or older who confirms this in writing within 30 days. The revocation is effective when the treating physician documents it in the medical record.
- ◆ Marrying after executing an advance directive for health care revokes any agent other than the declarant's spouse
- ◆ Divorcing or otherwise dissolving a marriage after the execution of an advance directive for health care revokes the designation of the spouse as the health care agent

What to do with the completed form

You should give a copy of this completed form to people who might need it, such as your health care agent, your family, and your physician. Keep a copy of this completed form at home in a place where it can easily be found if it is needed. Review this completed form periodically to make sure it still

reflects your preferences. If your preferences change, complete a new advance directive for health care.



This information was revised March 2016

Copies of this form and its instructions are available at no cost from the Georgia Department of Human Services Division of Aging Services, 2 Peachtree Street NW, Suite 33.384, Atlanta, GA 30303-3142. For additional information, call the Division at 1-866-552-4464.

GEORGIA ADVANCE DIRECTIVE FOR HEALTH CARE

By: _____ Date of Birth: _____
(Print Name) (mm/dd/yyyy)

This advance directive for health care has four parts:

PART ONE HEALTH CARE AGENT. *This part allows you to choose someone to make health care decisions for you when you cannot (or do not want to) make health care decisions for yourself. The person you choose is called a health care agent. You may also have your health care agent make decisions for you after your death with respect to an autopsy, organ donation, body donation, and final disposition of your body. You should talk to your health care agent about this important role.*

PART TWO TREATMENT PREFERENCES. *This part allows you to state your treatment preferences if you have a terminal condition or if you are in a state of permanent unconsciousness. PART TWO will become effective only if you are unable to communicate your treatment preferences. Reasonable and appropriate efforts will be made to communicate with you about your treatment preferences before PART TWO becomes effective. You should talk to your family and others close to you about your treatment preferences.*

PART THREE GUARDIANSHIP. *This part allows you to nominate a person to be your guardian should one ever be needed.*

PART FOUR EFFECTIVENESS AND SIGNATURES. *This part requires your signature and the signatures of two witnesses. You must complete PART FOUR if you have filled out any other part of this form. This document may be signed by you or signed by someone else for you in your presence and at your express direction.*

You may fill out any or all of the first three parts listed above. You must fill out PART FOUR of this form in order for this form to be effective.

PART ONE: HEALTH CARE AGENT

[PART ONE will be effective even if PART TWO is not completed. A physician or health care provider who is directly involved in your health care may not serve as your health care agent. If you are married, a future divorce or annulment of your marriage will revoke the selection of your current spouse as your health care agent. If you are not married, a future marriage will revoke the selection of your health care agent unless the person you selected as your health care agent is your new spouse.]

(1) HEALTH CARE AGENT

I select the following person as my health care agent to make health care decisions for me:

Name: _____

Address: _____

Telephone Numbers:

(Home)

(Work)

(Mobile/Cell)

E-Mail Address: _____

(2) BACK-UP HEALTH CARE AGENT

[This section is optional. PART ONE will be effective even if this section is left blank.]

If my health care agent cannot be contacted in a reasonable time period and cannot be located with reasonable efforts or for any reason my health care agent is unavailable or unable or unwilling to act as my health care agent, then I select the following, each to act successively in the order named, as my back-up health care agent(s):

First Back-up Agent

Name: _____

Address: _____

Telephone Numbers: _____

(Home, Work, and Mobile/Cell)

E-Mail Address: _____

Second Back-up Agent

Name: _____

Address: _____

Telephone Numbers: _____

(Home, Work, and Mobile/Cell)

E-Mail Address: _____

(3) GENERAL POWERS OF HEALTH CARE AGENT

My health care agent will make health care decisions for me when I am unable to communicate my health care decisions or I choose to have my health care agent communicate my health care decisions.

My health care agent will have the same authority to make any health care decision that I could make. My health care agent's authority includes the following powers:

- To authorize my admission to or discharge (including transfers) from any hospital, skilled nursing facility, hospice, or other health care facility or service;
- To request, consent to, withhold, or withdraw any type of health care; and to
- Contract for any health care facility or service for me, and to obligate me to pay for these services (and my health care agent, acting in this official capacity, will not be financially liable for any services or care contracted for me or on my behalf).

My health care agent will be my personal representative for all purposes of federal or state law related to privacy of medical records. This includes the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

My health care agent will have the same access to my medical records that I have and can disclose the contents of my medical records to others for my ongoing health care.

My health care agent may accompany me in an ambulance or air ambulance if in the opinion of the ambulance personnel protocol permits a passenger and my health care agent may visit or consult with me in person while I am

in a hospital, skilled nursing facility, hospice, or other health care facility or service if its protocol permits visitation.

My health care agent may present a copy of this advance directive for health care in lieu of the original and the copy will have the same meaning and effect as the original.

I understand that under Georgia law:

- My health care agent may refuse to act as my health care agent;
- A court can take away the powers of my health care agent if it finds that my health care agent is not acting properly; and
- My health care agent does not have the power to make health care decisions for me regarding psychosurgery, sterilization, or treatment or involuntary hospitalization for mental or emotional illness, developmental disability, or addictive disease.

(4) GUIDANCE FOR HEALTH CARE AGENT

When making health care decisions for me, my health care agent should think about what action would be consistent with past conversations we have had, my treatment preferences as expressed in PART TWO (if I have filled out PART TWO), my religious and other beliefs and values, and how I have handled medical and other important issues in the past. If what I would decide is still unclear, then my health care agent should make decisions for me that my health care agent believes are in my best interest, considering the benefits, burdens, and risks of my current circumstances and treatment options.

(5) POWERS OF HEALTH CARE AGENT AFTER DEATH

(A) AUTOPSY

My health care agent will have the power to authorize an autopsy of my body unless I have limited my health care agent's power by initialing below.

_____ (Initials) My health care agent will not have the power to authorize an autopsy of my body (unless an autopsy is required by law).

(B) ORGAN DONATION AND DONATION OF BODY

My health care agent will have the power to make a disposition of any part or all of my body for medical purposes pursuant to the Georgia Revised Uniform Anatomical Gift Act, unless I have limited my health care agent's power by initialing below.

[Initial each statement that you want to apply.]

_____ (Initials) My health care agent will not have the power to make a disposition of my body for use in a medical study program.

_____ (Initials) My health care agent will not have the power to donate any of my organs.

(C) FINAL DISPOSITION OF BODY

My health care agent will have the power to make decisions about the final disposition of my body **unless** I have initialed below.

_____ (Initials) I want the following person to make decisions about the final disposition of my body:

Name: _____

Address: _____

Telephone Numbers: _____

(Home, Work, and Mobile/Cell)

E-Mail Address: _____

I wish for my body to be:

_____ (Initials) Buried OR _____ (Initials) Cremated

PART TWO: TREATMENT PREFERENCES

[PART TWO will be effective only if you are unable to communicate your treatment preferences after reasonable and appropriate efforts have been made to communicate with you about your treatment preferences. PART TWO will be effective even if PART ONE is not completed. If you have not selected a health care agent in PART ONE, or if your health care agent is not available, then PART TWO will provide your physician and other health care providers with your treatment preferences. If you have selected a health care agent in PART ONE, then your health care agent will have the authority to make all health care decisions for you regarding matters covered by PART TWO. Your health care agent will be guided by your treatment preferences and other factors described in Section (4) of PART ONE.]

(6) CONDITIONS

PART TWO will be effective if I am in any of the following conditions:

[Initial each condition in which you want PART TWO to be effective.]

_____ (Initials) A terminal condition, which means I have an incurable or irreversible condition that will result in my death in a relatively short period of time.

_____ (Initials) A state of permanent unconsciousness, which means I am in an incurable or irreversible condition in which I am not aware of myself or my environment and I show no behavioral response to my environment.

My condition will be determined in writing after personal examination by my attending physician and a second physician in accordance with currently accepted medical standards.

(7) TREATMENT PREFERENCES

[State your treatment preference by initialing (A), (B), or (C). If you choose (C), state your additional treatment preferences by initialing one or more of the statements following (C). You may provide additional instructions about your treatment preferences in the next section. You will be provided with comfort care, including pain relief, but you may also want to state your specific preferences regarding pain relief in the next section.]

If I am in any condition that I initialed in Section (6) above and I can no longer communicate my treatment preferences after reasonable and appropriate efforts have been made to communicate with me about my treatment preferences, then:

(A) _____ (Initials) *Try to extend my life for as long as possible*, using all medications, machines, or other medical procedures that in reasonable medical judgment could keep me alive. If I am unable to take nutrition or fluids by mouth, then I want to receive nutrition or fluids by tube or other medical means.

OR

(B) _____ (Initials) *Allow my natural death to occur*. I do not want any medications, machines, or other medical procedures that in reasonable medical judgment could keep me alive but cannot cure me. I do not want to receive nutrition or fluids by tube or other medical means except as needed to provide pain medication.

OR

(C) _____ (Initials) I do not want any medications, machines, or other medical procedures that in reasonable medical judgment could keep me alive but cannot cure me, except as follows:

[Initial each statement that you want to apply to option (C).]

_____ (Initials) If I am unable to take nutrition by mouth, I want to receive nutrition by tube or other medical means.

_____ (Initials) If I am unable to take fluids by mouth, I want to receive fluids by tube or other medical means.

_____ (Initials) If I need assistance to breathe, I want to have a ventilator used.

_____ (Initials) If my heart or pulse has stopped, I want to have cardiopulmonary resuscitation (CPR) used.

(8) ADDITIONAL STATEMENTS

[This section is optional. PART TWO will be effective even if this section is left blank. This section allows you to state additional treatment preferences, to provide additional guidance to your health care agent (if you have selected a health care agent in PART ONE), or to provide information about your personal and religious values about your medical treatment. For example, you may want to state your treatment preferences regarding medications to fight infection, surgery, amputation, blood transfusion, or kidney dialysis. Understanding that you cannot foresee everything that could happen to you after you can no longer communicate your treatment preferences, you may want to provide guidance to your health care agent (if you have selected a health care agent in PART ONE) about following your treatment preferences. You may want to state your specific preferences regarding pain relief.]

(9) IN CASE OF PREGNANCY

[PART TWO will be effective even if this section is left blank.]

I understand that under Georgia law, PART TWO generally will have no force and effect if I am pregnant unless the fetus is not viable and I indicate by initialing below that I want PART TWO to be carried out.

_____ (Initials) I want PART TWO to be carried out if my fetus is not viable.

PART THREE: GUARDIANSHIP

(10) GUARDIANSHIP

[PART THREE is optional. This advance directive for health care will be effective even if PART THREE is left blank. If you wish to nominate a person to be your guardian in the event a court decides that a guardian should be appointed, complete PART THREE. A court will appoint a guardian for you if the court finds that you are not able to make significant responsible decisions for yourself regarding your personal support, safety, or welfare. A court will appoint the person nominated by you if the court finds that the appointment will serve your best interest and welfare. If you have selected a health care agent in PART ONE, you may (but are not required to) nominate the same person to be your guardian. If your health care agent and guardian are not the same person, your health care agent will have priority over your guardian in making your health care decisions, unless a court determines otherwise.]

[State your preference by initialing (A) or (B). Choose (A) only if you have also completed PART ONE.]

(A) _____ (Initials) I nominate the person serving as my health care agent under PART ONE to serve as my guardian.

OR

(B) _____ (Initials) I nominate the following person to serve as my guardian:

Name: _____

Address: _____

Telephone Numbers: _____

(Home, Work, and Mobile/Cell)

E-Mail Address: _____

PART FOUR: EFFECTIVENESS AND SIGNATURES

This advance directive for health care will become effective only if I am unable or choose not to make or communicate my own health care decisions.

Completing this form revokes and replaces any advance directive for health care, durable power of attorney for health care, health care proxy, or living will that I have completed before this date.

Unless I have initialed below and have provided alternative future dates or events, this advance directive for health care will become effective at the time I sign it and will remain effective until my death (and after my death to the extent authorized in Section (5) of PART ONE).

_____ (Initials) This advance directive for health care will become effective on or upon _____ and will terminate on or upon

(Optional: Specify a date or event)

_____.

(Optional: Specify a date or event)

[You must sign and date or acknowledge signing and dating this form in the presence of two witnesses.]

Both witnesses must be of sound mind and must be at least 18 years of age, but the witnesses do not have to be together or present with you when you sign this form.

A witness:

- Cannot be a person who was selected to be your health care agent or back-up health care agent in PART ONE;
- Cannot be a person who will knowingly inherit anything from you or otherwise knowingly gain a financial benefit from your death; or
- Cannot be a person who is directly involved in your health care.

Only one of the witnesses may be an employee, agent, or medical staff member of the hospital, skilled nursing facility, hospice, or other health care facility in which you are receiving health care (but this witness cannot be directly involved in your health care).]

By signing below, I state that I am emotionally and mentally capable of making this advance directive for health care and that I understand its purpose and effect.

(Signature of Declarant)

(Date)

The declarant signed this form in my presence or acknowledged signing this form to me. Based upon my personal observation, the declarant appeared to be emotionally and mentally capable of making this advance directive for health care and signed this form willingly and voluntarily.

(Signature of First Witness)

(Date)

Print Name: _____

Address: _____

(Signature of Second Witness)

(Date)

Print Name: _____

Address: _____

[This form does not need to be notarized and a copy of a validly executed advance directive for health care carries the same meaning and effect as the original 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)

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'.

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:

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:

