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INDIANA HEALTH CARE REPRESENTATIVE APPOINTMENT

State Form 56184 (11-16)

Indiana State Department of Health – IC 16-36-1; IC 16-36-6

INSTRUCTIONS: See instructions on back.

Patient / Appointor Information		
Patient Last Name	Patient First Name	Patient Middle Initial
Patient Birthday (<i>mm/dd/yyyy</i>)	Medical Record Number of Healthcare Facility or Provider (<i>optional</i>)	Healthcare Facility or Provider (<i>optional</i>)
Appointment of Health Care Representative		
<p>I, being at least eighteen (18) years of age, of sound mind, and capable of consenting to my health care, hereby appoint the person(s) named below as my lawful health care representative in all matters affecting my health care, including but not limited to providing consent or refusing to provide consent to medical care, surgery, and/or placement in health care facilities, including extended care facilities, unless otherwise provided in this appointment. This appointment shall become effective at such time and from time to time as my attending physician determines that I am incapable of consenting to my health care. I understand that if I have previously named a health care representative the designation below supersedes (replaces) any prior named Health Care Representative(s).</p> <p>I authorize my health care representative to make decisions in my best interest concerning withdrawal or withholding of health care. If at any time based on my previously expressed preferences and the diagnosis and prognosis my health care representative is satisfied that certain health care is not or would not be beneficial or that such health care is or would be excessively burdensome, then my health care representative may express my will that such health care be withheld or withdrawn and may consent on my behalf that any or all health care be discontinued or not instituted, even if death may result. My health care representative must try to discuss this decision with me. However, if I am unable to communicate, my health care representative may make such a decision for me, after consultation with my physician or physicians and other relevant health care givers. To the extent appropriate, my health care representative may also discuss this decision with my family and others to the extent they are available.</p> <p>I specify the following terms and conditions (<i>if any</i>):</p>		
Name of Representative Appointed	Address of Representative (<i>number and street, city, state, and ZIP code</i>)	Telephone Number of Representative
Signature of Patient / Appointor or Designee (<i>must be signed in the appointor's presence</i>)	Printed Name of Patient / Appointor or Designee	Date of Appointment (<i>mm/dd/yyyy</i>)
Signature of Witness	Printed Name of Witness	Date (<i>mm/dd/yyyy</i>)

INSTRUCTIONS FOR STATE FORM 56184, INDIANA HEALTH CARE REPRESENTATIVE APPOINTMENT

1. There are numerous types of advance directives. The Indiana State Department of Health encourages individuals to consult with their attorney, health planner, and health care providers in completing any advance directive.
2. This state form is not required for an appointment of a health care representative. An individual may use a form designed by their attorney or other entity to specifically meet the individual's needs. To be valid, any form must comply with statutory requirements.
3. An individual is not required to complete a health care representative appointment form. An individual may always choose to not appoint a health care representative. If there is no appointed representative, state medical consent laws would determine who may consent to your healthcare.
4. The medical record number and health care facility or provider is not required for the appointment to be effective. It may be included as a means of assisting the health care provider in identifying the correct patient and locating the appointment in the correct medical record.
5. The patient / appointor may specify in the appointment appropriate terms and conditions, including an authorization to the representative to delegate the authority to consent to another.
6. The authority granted becomes effective according to the terms of the appointment.
7. The appointment does not commence until the appointor becomes incapable of consenting. The authority granted in the appointment is not effective if the patient / appointor regains the capacity to consent.
8. Unless the appointment provides otherwise, a representative appointed under this section who is reasonably available and willing to act has priority to act in all matters of health care for the patient / appointor, except when the patient / appointor is capable of consenting.
9. The appointment of a health care representative must be witnessed by an adult other than the health care representative.
10. In making all decisions regarding the patient's / appointor's health care, the health care representative shall act:
 - a. In the best interest of the patient / appointor consistent with the purpose expressed in the appointment.
 - b. In good faith.
11. A health care representative who resigns or is unwilling to comply with the written appointment may not exercise further power under the appointment and shall so inform the following:
 - a. The patient / appointor.
 - b. The patient's / appointor's legal representative if one is known.
 - c. The health care provider if the representative knows there is one.
12. An individual who is capable of consenting to health care may revoke:
 - a. The appointment at any time by notifying the representative orally or in writing; or
 - b. The authority granted to the representative by notifying the health care provider orally or in writing.



INDIANA LIVING WILL DECLARATION

State Form 55316 (6-13)

Indiana State Department of Health – IC 16-36-4

This declaration is effective on the date of execution and remains in effect until revocation or the death of the declarant. This declaration should be provided to your physician.

LIVING WILL DECLARATION

Declaration made this _____ day of _____ (month, year). I, _____, being at least eighteen (18) years of age and of sound mind, willfully and voluntarily make known my desires that my dying shall not be artificially prolonged under the circumstances set forth below, and I declare:

If at any time my attending physician certifies in writing that:

- (1) I have an incurable injury, disease, or illness;
- (2) my death will occur within a short time; and
- (3) the use of life prolonging procedures would serve only to artificially prolong the dying process,

I direct that such procedures be withheld or withdrawn and that I be permitted to die naturally with only the performance or provision of any medical procedure or medication necessary to provide me with comfort care or to alleviate pain, and, if I have so indicated below, the provision of artificially supplied nutrition and hydration. (Indicate your choice by initialing or making your mark before signing this declaration.):

_____ I wish to receive artificially supplied nutrition and hydration, even if the effort to sustain life is futile or excessively burdensome to me.

_____ I do not wish to receive artificially supplied nutrition and hydration, if the effort to sustain life is futile or excessively burdensome to me.

_____ I intentionally make no decision concerning artificially supplied nutrition and hydration, leaving the decision to my health care representative appointed under IC 16-36-1-7 or my attorney in fact with health care powers under IC 30-5-5.

In the absence of my ability to give directions regarding the use of life prolonging procedures, it is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences of the refusal.

I understand the full import of this declaration.

Signed _____

City, County, and State of Residence

WITNESSES

The declarant has been personally known to me and I believe (him/her) to be of sound mind. I did not sign the declarant's signature above for or at the direction of the declarant. I am not a parent, spouse, or child of the declarant. I am not entitled to any part of the declarant's estate or directly financially responsible for the declarant's medical care. I am competent and at least eighteen (18) years of age.

Witness _____ Date (month, day, year) _____

Witness _____ Date (month, day, year) _____