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Name: _____

Address: _____

Phone: _____

ADVANCED DIRECTIVE

Declaration made this _____ day of _____, 20_____

I, _____, being of sound mind, willfully and voluntarily make known my desires that my dying shall not be artificially prolonged under the circumstances set forth below, do declare:

If at any time I should have an incurable injury, disease or illness certified to be a terminal condition by two physicians who have personally examined me, one of whom shall be my attending physician, and the physicians have determined that my death will occur whether or not life-sustaining procedures would serve only to prolong artificially the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

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

I hereby knowingly and purposefully waive any and all rights I may now have and in the future under the Health Insurance Portability and Accountability Act (HIPAA), Public Law 104-191, and the Department of Health and Human Services (HHS) Privacy Rule of 2000 (Standards for Privacy of Individually Identifiable Health Information) and thereby allow my doctors and all other health care providers, health care plans and clearinghouses, including the medical staff and short term medical facilities, to release all information regarding my medical history, status, diagnosis and treatment to my attorney and agent herein setout.

I understand the full import of this declaration, and I am emotionally and mentally competent to make this decision.

Signed: _____ Date: _____

I believe the above declarant to be of sound mind. I did not sign the declarant's signature above for or at the direction of the declarant I am at least eighteen (18) years of age and am not related to the declarant by blood or marriage, entitled to any portion

of the estate of the declarant according to the laws of intestate succession of this state or under any will of the declarant or codicil thereto, or directly financially responsible for declarant's medical care. I am not the declarant's attending physician.

Witness: _____ Date: _____

Address: _____

Witness: _____ Date: _____

Address: _____

In the alternative:

SUBSCRIBED AND SWORN TO BEFORE ME

this _____ day of _____, 20___.

Notary Public

LIVING WILL

I, _____, being of sound mind, willfully and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, do hereby declare:

If at any time I should have an incurable injury, disease, or illness certified to be a terminal condition by two physicians who have personally examined me, one of whom shall be my attending physician, and the physicians have determined that my death will occur whether or not life sustaining procedures are utilized and where application of life sustaining 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 administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care.

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

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

Signed:_____ Date:_____

Place of Residence:

_____ _____

Witness Address

_____ _____

Witness Address

Witnesses must be adults, not related by blood or marriage, not heirs by law or by will, and not financially responsible for Declarer's medical care.

After signing, give to your doctor to place in your medical records.