ADVANCE HEALTH CARE DIRECTIVE
OF
[NAME]

PART I

DURABLE HEALTH CARE POWER OF ATTORNEY

I, of County, Pennsylvania, appoint the person named below to be my health care agent and to make health and personal care decisions for me. My health care agent may not delegate the authority to make decisions under this Advance Health Care Directive.

Effective immediately and continuously until my death or until revocation by a writing signed by me or by someone authorized to make health care treatment decisions for me, I authorize all health care providers and other covered entities to disclose to my health care agent, upon my agent's request, any information, oral or written, regarding my physical or mental health, including, but not limited to, medical and hospital records and what is otherwise private, privileged, protected or personal health information, such as health information as defined and described in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the regulations promulgated thereunder and any other state or local laws and rules. I recognize that the information disclosed by a health care provider or other covered entity may be redisclosed and may no longer be subject to the privacy rules provided by HIPAA regulations.

My health care agent has all of the following powers, subject to the health care treatment instructions that follow in Part II:

1. To authorize, arrange for, consent to and withhold, withhold consent from, waive, withdraw or terminate any and all medical, therapeutical and surgical care, treatments and procedures for me, including, without limitation, the administration of drugs.

2. To apply for my admission to, authorize or refuse admission to, and authorize or refuse transfer to or discharge from a medical, nursing, residential or other similar facility; execute any consent or admission forms required by such facility; and enter into agreements for my care, including hospice and palliative care, by such facility or elsewhere during my lifetime or for such lesser period of time as my agent may designate, including the hiring and firing of medical, social services and other support personnel responsible for my care.

3. To authorize the payment of all bills for my health and medical care, and have access to and complete insurance and other health record forms, applications, certifications and other documentation.

4. To bring any legal action necessary to enforce my rights under this Durable Health Care Power of Attorney and Living Will.

5. To authorize, withhold or withdraw nutrition (food) or hydration (water) medically supplied by tube through my nose, stomach, intestines, arteries or veins.

6. To request that a physician responsible for my care issue a do-not-resuscitate (DNR) order, including an out-of-hospital DNR order, DNR bracelet or DNR necklace, and sign any required documents and consents.

In addition, if I should suffer from severe and irreversible brain damage or brain disease with no realistic hope of significant recovery, I would consider such a condition intolerable and the application of aggressive medical care to be burdensome. I therefore request that my health care agent respond to any intervening (other and separate) life-threatening conditions in the same manner as directed for an end-stage medical condition or state of permanent unconsciousness as I have indicated in Part II below.

APPOINTMENT OF HEALTH CARE AGENT

I appoint the following health care agent:

Health Care Agent: _____
Relationship _____
Address: _____
_____
Telephone Number: Home: _____ Work: _____
E-Mail: _____

If the agent appointed above is, for any reason, unable or unavailable to act, I appoint

and jointly and severally, to act as successor agents.

Such agents' pertinent information is as follows:

Alternative Health Care Agent: _____
Relationship _____
Address: _____
_____
Telephone Number: Home: _____ Work: _____
E-Mail: _____

Alternative Health Care Agent: _____
Relationship _____
Address: _____
_____
Telephone Number: Home: _____ Work: _____
E-Mail: _____

As I have designated my successor agents jointly and severally, it is my intention that they may act on my behalf hereunder together, or either one may act on my behalf hereunder separately.

PART II

LIVING WILL
(HEALTH CARE TREATMENT INSTRUCTIONS IN THE EVENT OF END-STAGE MEDICAL CONDITION OR PERMANENT UNCONSCIOUSNESS)

INSTRUCTIONS

The following health care treatment instructions exercise my right to make my own health care decisions. These instructions are intended to provide clear and convincing evidence of my wishes to be followed when I lack the capacity to understand, make or communicate my treatment decisions:

If I have an end-stage medical condition (which will result in my death, despite the introduction or continuation of medical treatment) or am permanently unconscious such as in an irreversible coma or an irreversible vegetative state and there is no realistic hope of significant recovery, all of the following apply:

1. I direct that I be given health care treatment to relieve pain or provide comfort even if such treatment might shorten my life, suppress my appetite or my breathing, or be habit-forming.

2. I direct that all life prolonging procedures be withheld or withdrawn unless otherwise qualified below.

3. I specifically do not want any of the following as life prolonging procedures or products: *(If you wish to receive any of these treatments or products, write "I do want" after the treatment)*

- cardiac or cardiopulmonary resuscitation, cardiac compression or any of the common medications or procedures, such as defibrillation or other treatments, used in connection with cardiac or cardiopulmonary resuscitation. _____
- any invasive airway techniques, endotracheal intubation, mechanical respiration, artificial ventilation, bag valve mask or related treatments _____
- kidney dialysis _____
- blood or blood products_____
- chemotherapy _____
- radiation treatment _____
- antibiotics _____

4. I specifically do not want nutrition (food) or hydration (water) medically supplied by a tube into my nose, stomach, intestine, arteries, or veins. *(If you wish to receive any of these treatments, write "I do want" and the specific treatment here)*._____

_____

5. My goals for making medical decisions are as follows: *(insert your personal priorities such as comfort, care, preservation of mental function, etc.)*: _____

_____

_____

_____

_____

_____

HEALTH CARE AGENT'S USE OF INSTRUCTIONS (*Initial one option only.*)

_____ My health care agent must follow these instructions.

OR

_____ These instructions are only guidance. My health care agent shall have final say and may override any of my instructions. (*Indicate any exceptions.*) _____

_____

If I did not appoint a health care agent, these instructions shall be followed.

ORGAN DONATION (*Initial one option only.*)

_____ I donate my organs and tissues at the time of my death for the purpose of transplant, medical study or education. (*If you desire, insert name of donee or any limitations on donation of specific organs or tissues or uses for donation of organs and tissues.*) _____

_____

_____

OR

_____ I do not consent to donate my organs or tissues at the time of my death.

OR

_____ I authorize my health care agent designated in this Advance Health Care Directive, in my health care agent's sole discretion, to arrange and consent to procedures to make an anatomical gift of all or part of my body in accordance with Pennsylvania law.

Pennsylvania law protects my health care agent and health care providers from any legal liability for their good faith actions in following my wishes as expressed in this form or in complying with my health care agent's direction. On behalf of myself, my executors and heirs, I further hold my health care agent and my health care providers harmless and indemnify them against any claim for their good faith actions in recognizing my health care agent's authority or in following my treatment instructions.

This Advance Health Care Directive shall not be affected by my subsequent disability or incapacity. This Advance Health Care Directive shall be valid despite the lapse of time since execution.

Should any specific provision in this Advance Health Care Directive be held to be invalid, such invalidity shall not invalidate other provisions of this document that can be effective without the invalid provision.

SIGNATURE

Having carefully read this document, I have signed it this _____ day of _____, 20 , revoking all previous health care powers of attorney and health care treatment instructions.

_____
[NAME ANN ADDRESS]

The declarant, , knowingly and voluntarily signed this Advance Health Care Directive by signature in my presence.

Witness: _____

Witness Printed Name: _____

Witness Address: _____

Witness: _____

Witness Printed Name: _____

Witness Address: _____

COMMONWEALTH OF PENNSYLVANIA :
: ss
COUNTY OF :

On this day of , 20 , before me, a Notary Public, in and for the Commonwealth of Pennsylvania, personally appeared the above named and acknowledged the foregoing Advance Health Care Directive to be his act and deed and desired that the same might be recorded as such.

WITNESS my hand and seal the day and year aforesaid.

_____
Notary Public
My commission expires: