HEALTH CARE DIRECTIVE
OF
_____

This Health Care Directive shall revoke any prior document granting a power in conflict with a power granted herein. I, _____, born on _____, and currently residing at _____ understand this document allows me to do **ONE OR BOTH** of the following:

PART I: Name another person ("health care agent") to make health care decisions for me if I am unable to decide or speak for myself. My health care agent must make health care decisions for me based on the instructions I provide in this document (Part II), if any, the wishes I have made known to him or her, or must act in my best interest if I have not made my health care wishes known.

AND/OR

PART II: Give health care instructions to guide others making health care decisions for me. If I have named a health care agent, these instructions are to be used by the agent. These instructions may also be used by my health care providers, others assisting with my health care and my family, in the event I cannot make decisions for myself.

PART I
POWER OF ATTORNEY APPOINTING HEALTH CARE AGENT

This Is Who I Want to Make Health Care Decisions for Me If I Am Unable to Decide or Speak for Myself

NOTE: If you appoint an agent, you should discuss this health care directive with your agent and give your agent a copy. If you do not wish to appoint an agent, you may leave Part I blank and go to Part II.

If I am unable to decide or communicate my instructions, I designate the following person(s) as my health care agent to make health care decisions for me and act on my behalf consistently with my instructions, if any, as stated or limited in this document. If a guardian or conservator of the person is to be appointed for me, I nominate my agent named in this document to act as guardian or conservator of my person.

Name: _____ Relationship: _____

Address: _____

_____

Phone Number: _____

If that person I have named above refuses or is not reasonably available to act on my behalf, or if I revoke that person's authority to act as my agent, I authorize the following person to do so:

Name: _____ Relationship: _____

Address: _____

_____

Phone Number: _____

This Is What I Want My Health Care Agent to Be Able to Do If I Am Unable to Decide or Speak for Myself (I know I can change these choices)

My health care agent is automatically given the powers indicated below in (A) through (D). My health care agent must follow my health care instructions in this document or any other instructions I have given to my agent. If I have not given health care instructions, then my agent must act in my best interest.

Whenever I am unable to decide or speak for myself, my health care agent has the power to:

(A) Make any health care decision for me. This includes the power to give, refuse, or withdraw consent to any care, treatment, service, or procedures. This includes deciding whether to stop or not start health care that is keeping me or might keep me alive, and deciding about intrusive mental health treatment.

(B) Choose my health care providers.

(C) Choose where I live and receive care and support when those choices relate to my health care needs.

(D) Review my medical records and have the same rights that I would have to give my medical records to other people.

If I DO NOT want my health care agent to have a power in (A) through (D) or if I choose to LIMIT a power granted in (A) through (D), I MUST say that here:

_____

_____

_____

My health care agent is given the powers indicated by my initials below in (1) and (2).

_____ (1) To decide whether to donate my organs when I die.

_____ (2) To decide what will happen with my body when I die (burial, cremation).

Additional comments regarding my health care agent's powers or limits on the powers:

PART II
HEALTH CARE INSTRUCTIONS

NOTE: Complete this Part II if you wish to give health care instructions. If you appointed an agent in Part I, completing this Part II is optional but would be very helpful to your agent. However, if you chose not to appoint an agent in Part I, you MUST complete some or all of this Part II if you wish to make a valid health care directive.

These are instructions for my health care when I am unable to decide or speak for myself. These instructions must be followed (so long as they address my needs).

THESE ARE MY BELIEFS AND VALUES ABOUT MY HEALTH CARE

I want you to know these things about me to help you make decisions about my health care:

My goals for my health care:

My fears about my health care:

My spiritual or religious beliefs and traditions:

My beliefs about when life would be no longer worth living:

My thoughts about how my medical condition might affect my family:

THIS IS WHAT I WANT AND DO NOT WANT FOR MY HEALTH CARE

Many medical treatments may be used to try to improve my medical condition or to prolong my life. Examples include artificial breathing by a machine connected to a tube in the lungs, artificial feeding or fluids through tubes, attempts to start a stopped heart, surgeries, dialysis, antibiotics and blood transfusions. Most medical treatments can be tried for a while and then stopped if they do not help.

I have these views about my health care in these situations: (Note: You can discuss general feelings, specific treatments, or leave any of them blank.)

If I had a reasonable chance of recovery, and were temporarily unable to decide or speak for myself, I would want _____

If I were dying and unable to decide or speak for myself, I would want _____

If I were permanently unconscious and unable to decide or speak for myself, I would want

If I were completely dependent on others for my care and unable to decide or speak for myself, I would want _____

In all circumstances, my doctors should try to keep me comfortable and reduce my pain. This is how I feel about pain relief if it would affect my alertness or if it could shorten my life: _

There are other things that I want or do not want for my health care, if possible:

Who I would like to be my doctor: _____
Where I would like to live to receive health care: _____

Where I would like to die or other wishes I have about dying: _____

My wishes about donating parts of my body when I die: _____

My wishes about what happens to my body when I die (cremation, burial): _____

Any other things: _____

Date: _____, 20__

I am thinking clearly, I agree with everything that is written in this document, and I have made this document willingly.

_____
(Signature of Principal)

STATE OF MINNESOTA)
) ss.
COUNTY OF _____)

Subscribed, sworn to, and acknowledged before me by _____ on this _____ day of _____, 20__.

_____
Notary Public

- OR -

WITNESS

I certify that I am at least 18 years of age and that in my presence on the date appearing above, the principal, _____, personally known to me, voluntarily signed this instrument. I am not named as agent or alternative agent in the instrument. I (am __) (am not ___) a Health Care Provider or employee of a Health Care Provider providing direct care to _____.

Witness_____ residing at _____
_____

WITNESS

I certify that I am at least 18 years of age and that in my presence on the date appearing above, the principal, _____, personally known to me, voluntarily signed this instrument. I am not named as agent or alternative agent in the instrument. I (am__) (am not__) a Health Care Provider or employee of a Health Care Provider providing direct care to _____.

Witness_____ residing at _____
_____

REMINDER: Keep this document with your personal papers in a safe place (not in a safe deposit box). Give signed copies to your doctors, family, close friends, health care agent, and alternate health care agent. Make sure your doctor is willing to follow your wishes. This document should be part of your medical record at your physician's office and at the hospital, home care agency, hospice, or nursing facility where you receive your care.

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. I authorize all health care providers, including physicians, nurses, and all other persons (including entities) who may have provided, or be providing, me with any type of health care, to disclose all of my protected health information:

(a) to an agent acting under a durable power of attorney signed by me when asked by my agent to do so for the purpose of determining my capacity as defined in the power of attorney or by governing law;

(b) to the trustee, or a designated successor trustee, of any trust of which I am a beneficiary or a trustee when asked to do so for the purpose of determining my capacity as defined in the trust;

(c) to any partner of any partnership of which I am a member for the purpose of determining my capacity as defined in the partnership agreement;

(d) to my lawyer for the purposes of determining my capacity to make inter vivos gifts, to execute estate planning documents, and whether, and to what extent, a guardianship or other protective proceedings for me is necessary or desirable; and

(e) to a guardian ad litem, if one is appointed for me, for the purpose of determining whether, and to what extent, a guardianship or other protective proceedings for me is necessary or desirable; and

(f) to a health care agent acting under a health care power of attorney or a health care directive once I am unable to decide or communicate my instructions.

2. This authorization is intended to provide my health care providers with the authorization necessary to allow each of them to disclose protected health information regarding me to the persons described in (a)-(f) above for the purpose of allowing each of them to make the specified determinations regarding my capacity or need for protective proceedings.

3. Information disclosed by a health care provider pursuant to this authorization is subject to redisclosure and may no longer be protected by the privacy rules of 45 CFR § 164.

4. This authorization may be revoked by a writing signed by me or by my personal representative.

5. This authorization shall expire five (5) years after my death unless validly revoked prior to that date.

SIGNED: _____ DATED: _____, 20__