

ADVANCE HEALTHCARE DIRECTIVE

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This Advance Healthcare Directive (this "**Directive**") is made on [DATE] by [PRINCIPAL FULL LEGAL NAME], residing at [PRINCIPAL ADDRESS], born on [DATE OF BIRTH] (the "**Principal**," "**I**," or "**me**").

Recitals. I am an adult of sound mind. I want to ensure that my healthcare wishes are known and respected, and that a trusted person is authorized to make medical decisions for me if I cannot make them myself. This Directive combines two things: the appointment of a healthcare agent (a healthcare power of attorney) and a statement of my treatment wishes (an instruction directive or living will). I intend this Directive to be honored to the fullest extent permitted by the laws of the State of [STATE]. In recognition of my right to direct my own medical care, I declare as follows.

1. Purpose and Definitions

1.1 Purpose. The purpose of this Directive is to (a) name an agent to make healthcare decisions for me when I am unable to do so, and (b) record my wishes about the medical care I do and do not want, so those wishes guide my agent and my providers.

1.2 Defined terms. "**Agent**" means the person I appoint in Section 2 to make healthcare decisions for me. "**Healthcare decision**" means consent to, refusal of, or withdrawal of any medical care, treatment, service, or procedure, and related decisions about providers, facilities, and records. "**Attending physician**" means the physician with primary responsibility for my care.

1.3 Adult of sound mind. I am at least [18] years old, of sound mind, and acting freely and voluntarily, and I understand the nature and effect of this Directive.

2. Appointment of Healthcare Agent

2.1 Primary Agent. I appoint the following person as my Agent to make healthcare decisions for me:

Name: [AGENT NAME]; Relationship: [RELATIONSHIP]; Address: [ADDRESS]; Phone: [PHONE].

2.2 Alternate Agents. If my primary Agent is unable, unwilling, or unavailable to serve, I appoint the following alternates, in order:

First alternate: [NAME, RELATIONSHIP, PHONE]. Second alternate: [NAME, RELATIONSHIP, PHONE].

2.3 Acceptance. Each Agent who acts under this Directive accepts the appointment and agrees to act in good faith and consistently with my wishes as expressed here and as otherwise known to the Agent.

2.4 Ineligible persons. I understand that, under the law of many jurisdictions, my attending physician, an owner or operator of my healthcare facility, or an employee of either may not serve as my Agent unless related to me. I have not appointed any such person unless permitted by law.

3. When the Agent's Authority Begins and Ends

3.1 When authority begins. My Agent's authority begins when my attending physician determines and documents that I lack the capacity to make my own healthcare decisions. **[OPTIONAL: I instead direct that my Agent's authority be effective immediately and concurrently with my own, to the extent permitted by law.]**

3.2 Determination of capacity. Lack of capacity must be determined by my attending physician and, where required by law, confirmed by a second qualified healthcare professional, and documented in my medical record.

3.3 When authority ends. My Agent's authority ends when I regain capacity, on my death (except for post-death decisions expressly authorized in Section 6), or on my revocation of the appointment under Section 8.

4. Scope of the Agent's Authority

4.1 General authority. Subject to my instructions in Section 5, my Agent may make any healthcare decision I could make for myself, including the authority to: (a) consent to, refuse, or withdraw any treatment; (b) select or discharge providers and facilities; (c) approve or refuse tests, surgery, and medication; and (d) authorize admission to or discharge from a hospital, nursing home, or hospice.

4.2 Access to records. I authorize my Agent to receive and disclose my medical information, including protected health information, to the extent needed to make informed decisions. This authorization is intended to comply with applicable health-privacy laws and survives until my Agent's authority ends.

4.3 Duty to follow my wishes. My Agent must make decisions consistent with my wishes as stated in this Directive and as otherwise known to the Agent. If my wishes are not known, my Agent must act in my best interest, considering my values and what the Agent believes I would choose.

4.4 Limits I place on the Agent. I place the following limits on my Agent's authority (or write "none"): **[LIST LIMITS OR "NONE"]**.

5. My Healthcare Instructions

5.1 End-of-life direction (initial one). If I am in a terminal condition, permanently unconscious, or in an end-stage condition with no reasonable expectation of recovery, then:

(a) ____ I do **not** want life-sustaining treatment that only prolongs the dying process; I want to be allowed to die naturally.

(b) ____ I **want** life-sustaining treatment provided to the fullest extent medically appropriate.

(c) ____ I want my Agent to decide based on the medical facts and my values at the time.

5.2 Artificial nutrition and hydration (initial one).

(a) ____ Withhold or withdraw artificially administered nutrition and hydration if I am in a condition described in 5.1.

(b) ____ Provide artificial nutrition and hydration even if other life-sustaining treatment is withheld.

(c) ____ Let my Agent decide.

5.3 Comfort care. Regardless of any other instruction, I want to be kept comfortable and free of pain, and to receive medication and care to relieve suffering, even if it may unintentionally hasten my death. I want palliative or hospice care made available where appropriate.

5.4 **Other wishes.** Other instructions about my values, religious or spiritual preferences, place of care, or specific treatments: **[DESCRIBE OR "NONE"]**.

5.5 **Pregnancy.** If I am pregnant, this Directive will be applied as follows: **[STATE WISHES]**, consistent with the mandatory requirements of applicable law.

6. Anatomical Gifts, Autopsy, and Disposition

6.1 **Organ and tissue donation (initial one).** (a) ____ I wish to donate any needed organs, tissues, or eyes. (b) ____ I wish to donate only: **[SPECIFY]**. (c) ____ I do not wish to donate.

6.2 **Autopsy.** My wishes regarding autopsy are: **[CONSENT / DECLINE / AS REQUIRED BY LAW / AGENT DECIDES]**.

6.3 **Disposition of remains.** My preferences for the disposition of my remains are: **[DESCRIBE OR "ADDRESSED ELSEWHERE"]**. My Agent is authorized to carry out these wishes to the extent permitted by law.

7. Provider Obligations and Immunity

7.1 **Direction to providers.** I direct my healthcare providers to follow the decisions of my Agent and the instructions in this Directive as if they were my own decisions made while I had capacity.

7.2 **Good-faith immunity.** Healthcare providers and my Agent who act in good faith under this Directive are entitled to the protections available under the laws of the State of **[STATE]**.

7.3 **Conscientious objection.** If a provider cannot in good conscience follow my wishes, I direct that provider to promptly inform my Agent and to assist in transferring my care to a provider who will honor this Directive.

8. Revocation, Copies, and General Provisions

8.1 **Revocation.** I may revoke this Directive or any part of it at any time and in any manner that communicates my intent to revoke, including a signed writing, destruction of the document, or an oral statement to my physician or another witness, regardless of my physical or mental condition.

8.2 **Revoking the Agent appointment.** I may revoke the appointment of my Agent by notifying the Agent or my provider orally or in writing. Unless I state otherwise, designating a new Agent revokes any prior designation.

8.3 **Prior directives.** This Directive revokes any prior healthcare power of attorney or instruction directive I have signed, except as I state here: **[STATE EXCEPTIONS OR "NONE"]**.

8.4 **Copies.** A photocopy, facsimile, or electronic copy of this signed Directive has the same effect as the original. I intend to give copies to my Agent, my alternates, and my primary physician.

8.5 **Severability and governing law.** If any provision is invalid, the rest remains in effect. This Directive is governed by the laws of the State of **[STATE]**.

SIGNATURE OF PRINCIPAL

I sign this Directive knowingly, voluntarily, and after careful thought.

PRINCIPAL

Signature: _____ Date: _____

Printed name: **[PRINCIPAL NAME]**

WITNESSES. I declare that the Principal signed this Directive in my presence, appears to be of sound mind and free from duress, and that I am not the named Agent, the Principal's attending physician, or (where prohibited by law) a person who would benefit from the Principal's estate. Witness and notarization requirements vary by jurisdiction; confirm the requirements under the law of the State of **[STATE]**.

WITNESS 1

WITNESS 2

Signature: _____

Signature: _____

Printed name: **[NAME]**

Printed name: **[NAME]**

Address: **[ADDRESS]**

Address: **[ADDRESS]**

Date: _____

Date: _____

NOTARY ACKNOWLEDGMENT (if required by **[STATE]).**

State of **[STATE]**, County of **[COUNTY]**. Acknowledged before me on **[DATE]** by **[PRINCIPAL NAME]**.

Notary Public: _____ My commission expires: **[DATE]**

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