THE DOCUMENT DOES NOT, AND IS NOT INTENDED TO, CONSTITUTE LEGAL ADVICE; INSTEAD, IT IS FOR GENERAL INFORMATIONAL PURPOSES ONLY. YOU SHOULD SEEK THE ADVICE OF A LICENSED ATTORNEY BEFORE EXECUTING THIS DOCUMENT, AND USERS SHOULD NOT RELY ON THIS FORM FOR LEGAL COMPLIANCE.

ADVANCE HEALTH CARE DIRECTIVE

(Hawaii Statute § 327E-3)

This form communicates to your care providers how you would like to be cared for if you cannot make decisions for yourself:

Request that any health care provider who receives a copy of this document make it a part of your medical records, accessible to anyone in charge of your care in the case that you are unable to make health care decisions for yourself. If the health care provider will not agree to follow what you request in this document, they should inform you and/or whoever is making care decisions on your behalf.

OUTLINE

ARTICLE I Introduction (p. 2 – 3): Considerations to help you choose an Agent who will make the same health care decisions on your behalf that you would make for yourself.

ARTICLE II Part I (p. 1): Form that appoints your Agent
(p. 2): Your official statement of your Agent's authority
Part II (p. 3 – 5): Instructions to your Agent and health care provider about your health care choices
Part III (p. 5 – 6): Authority for your Agent to see your medical records and other miscellaneous provisions
Part IV (p. 7 – 9): Execution requirements **(Your Signature is Required; Witnesses' Signatures or Notary Acknowledgment is Required)**

What should you do with this form?

- Please share this form with your family, friends, and medical providers.
- Please make sure copies of this form are placed in your medical record at all the places you get care.

What if you have questions about the form?

• It is OK to skip any part of this form if you have questions or do not want to answer.

- **Ask your doctors, nurses, social workers, family, or friends to help.**
- **Lawyers can help too. This form does not give legal advice.**

ARTICLE I

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CAREFULLY CONSIDER THE FOLLOWING AS IT WILL HELP YOU RECEIVE THE CARE YOU TRULY WANT

SUPPLEMENTED EXPLANATION REGARDING ADVANCE HEALTH CARE DIRECTIVE

(Hawaii Statute § 327E-3)

This is a form that gives you a voice in your healthcare when you cannot speak for yourself. **Before signing this form, consider the following pages 2-3 which tell you more about what your rights are as a patient, and what kind of decisions others can make on your behalf if you are not capable of making them yourself.**

You have the power to give instructions about your own health care and the power to name someone else to make those health care decisions for you if you are not able.

The Agent that you choose in this document will have the responsibility of making all health care decisions for you, **meaning your Agent has the power to make all the same health care decisions on your behalf that you could make yourself.** This document sets up guidelines and rules for your Agent to follow. For example, in a situation where you had failed to set up any direction to your Agent, he or she would potentially have the authority to tell your doctor to stop giving you a treatment necessary to keep you alive (think intravenous food and water).

It is important to know that your agent can make all the same decisions about your care that you could make yourself if you were able. This includes the power to:

- choose or refuse any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect any physical or mental condition including procedures like dialysis.
- change your doctor or health care institution.
- approve or disapprove diagnostic tests, surgical procedures, and programs of medication.
- direct the giving, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care, including resuscitation (trying to reactivate your lungs and heart). This would include the authority to have you put on or taken off a breathing machine and feeding tube.

- sign you up as an organ donor or have you autopsied.
- make personal care decisions, including determining where you will live.

The following people may <u>not</u> act as your health care agent:

- **An owner, operator, or employee of a health-care institution where you are receiving care, unless you are related by blood, marriage, or adoption.**

Since your Agent has so much authority and responsibility, you should not sign this form until you are confident it expresses your wishes (and not another person's wishes), and it expresses them in a way that your Agent will understand. Your Agent should be someone who you believe will understand, communicate, and insist on your getting the care you would ask for if you were able.

There is no expiration date to this document, but **you can change your mind at any time if you have capacity**—you simply change and sign another health care directive that revokes any prior health care directives.

THIS DOCUMENT DOES NOT, AND IS NOT INTENDED TO, CONSTITUTE LEGAL ADVICE; INSTEAD, IT IS FOR GENERAL INFORMATIONAL PURPOSES ONLY. YOU SHOULD SEEK THE ADVICE OF A LICENSED ATTORNEY BEFORE EXECUTING THIS DOCUMENT, AND USERS SHOULD NOT RELY ON THIS FORM FOR LEGAL COMPLIANCE.

ARTICLE II

ADVANCE HEALTH CARE DIRECTIVE

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

By this document, I, _____ [your name], of _____ [street address], _____ [city, state, and zip code], intend to and do hereby create an advance health care directive under Hawaii Statute § 327E-3. This advance directive shall not be affected by my subsequent disability or incapacity.

PART I

1.1 Designation of Health Care Agent.

I _____ [My name] do hereby designate and appoint _____ [Agents' name] of _____ [street address], _____ [city, state, and zip code], whose telephone number is _____, as my Agent to make health care decisions for me as authorized in this document. For the purposes of this document, "health care decision" means any decision regarding any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect my physical or mental condition.

1.2 Alternate Agents.

If _____ [Agent's name] is not available or becomes ineligible to act as my Agent, then I designate _____ [1st Alternate Agent] of _____ [street address], _____ [city, state, and zip code], whose telephone number is _____. If _____ [1st Alternate Agent] is not available or becomes ineligible to act as my alternate Agent, then I designate _____ [2nd Alternate Agent] of

_____ [street address], _____ [city, state, and zip code], whose telephone number is _____.

1.3 General Statement of Authority Granted to My Agent.

I give my Agent full power and authority:

- To make **health care decisions for me** to the same extent that I could make those decisions for myself if I were able, because my Agent shall know what health care decisions I would make if I were able based:
  1. Firstly, on the wishes I express in this document.
  2. And beyond the wishes expressed here, by deeper, more detailed communication between us.

I give my Agent full power and authority:

- To make **personal care decisions for me** to the same extent that I could make those decisions for myself if I were able, including: determining (1) where I will live (2) providing me meals (3) identifying household employees (4) determining transportation, (5) assisting with correspondence (6) and arranging recreation and entertainment for me. My Agent shall make these health care decisions that are consistent with my desires as stated in this document or otherwise made known to my Agent.

1.4 Period During Which Agent's Authority Is Effective. My Agent's authority starts when I am unable to make my own health care decisions (I become incapacitated) and ends when I am again able to make my own health care decisions (I regain capacity).

1.5 Agent's Obligation. My Agent will make health care decisions for me according to this document, especially informed by any instructions I give in Part 2 (page 3) of this form. If my Agent is not sure what my care wishes would be because they are not explicitly covered here, my Agent will choose whatever health care he or she believes is in my best interest. My Agent will look to my personal values to decide what is in my best interest.

1.6 Nomination of Guardian of the Person. If a guardian of my person needs to be appointed for me by a court, I nominate the Agent I named in this form. If that Agent is not willing, able, or reasonably available to act as guardian of my person, I nominate the alternate Agents whom I have named, in the same order as they are listed here. Any person who has been appointed in the past to be my guardian of my person, I nominate will be replaced now with the Agent named in this form.

PART II

INSTRUCTIONS FOR HEALTH CARE

When I am unable to make my own health care decisions, my Agent shall act according to the health care wishes I express here in Part II:

GENERAL INSTRUCTIONS

2.1 General Instruction Concerning Health Care. I want to receive all medical treatments available, according to current standards of care.

- I do not want to receive treatments that, depending on my specific medical circumstances, are (1) useless (they will not achieve their intended purpose) or (2) excessively burdensome (the likely harms or risks clearly outweighs the potential benefits).

EXCEPTIONS TO GENERAL INSTRUCTIONS

2.2 Exceptions to General Instruction Concerning Health Care. If any of the situations arise that I am about to describe, my Agent will make decisions according to the following instructions rather than those in the general instructions above. The care wishes I detail in sections 2.2.1-2.2.7 should be followed strictly.

2.2.1 I Want Pain Relief. I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death, so long as it is neither used to cause my death, nor is intended to do so.

2.2.2 I Want Nutrition and Hydration. I want my health care provider to provide me with nutrition and hydration orally so long as I am able to safely swallow them, or intravenously, by tube, or by other means to the full extent necessary both to (1) preserve my life and (2) to assure me the optimal health. I want nutrition, hydration, pain relief, and ordinary nursing care be continued, unless nutrition or hydration stops benefiting my health, for example, when my body stops absorbing them. A feeding tube can ONLY be withheld or withdrawn from me if:

- I have an incurable terminal illness or injury where I am in the final stage of dying and it is medically certain that my death will occur within hours or a few days, **and**
- The withholding or withdrawal of oral feeding or a feeding tube would not cause me to die of malnutrition or dehydration, or complications of malnutrition or dehydration.

2.2.3 I Want Nursing and Comfort Care. I also want to be provided basic nursing care and procedures to provide comfort care.

2.2.4 I Reject Euthanasia, Assisted Suicide, Medical Aid-In-Dying, Death With Dignity, and similar acts or omissions. I reject any action or inaction that is intended to cause or hasten my death. I understand and do not reject treatments, like some pain care, that may result in hastening my death but that **are not intended** to cause or hasten death.

2.2.5 I Want My Agent to Decide About Organ Donation. I want my agent to consider any prior statements or authorizations I have made regarding organ donation, but I give my agent the authority to revoke any prior authorization I have made and to refuse donation of my organs or tissues. I specifically deny any presumed consent for organ or tissue donation.

2.2.6 I Reject Non-consensual Removal or Withdrawal of Life-Supportive Treatments. I specifically deny any presumed consent for removal or withdrawal of life-supportive treatments (for example: ventilator, intravenous food and water). I direct that life-supportive treatments shall be removed or withdrawn only with the written consent of my Agent.

2.2.7 I Want Certain Protections Before Life-Sustaining Treatment Is Withdrawn. In the event that my physician diagnoses me as imminently dying, and thereby recommends that my Agent authorize withdrawal of life-supportive measures, I direct that a second physician be consulted as to that diagnosis and prognosis.

In the event that my physician diagnoses me as being in a persistent or chronic vegetative state, I direct that my health care providers follow the current standards of care for diagnosis, prognosis and treatment, and fully inform my Agent of the circumstances and various possible outcomes. My Agent will then determine the waiting period before life-sustaining treatment is withdrawn. My Agent has full authority to wait and see whether I will regain consciousness to a degree that is acceptable to me, acceptability being based on factors we have discussed.

If my state is such that withdrawal of life support is being considered, I still desire health care for easily treatable acute and chronic conditions, and health care that is intended to relieve pain or to make me comfortable.

PART III
MISCELLANEOUS MATTERS

3.1 Inspection and Disclosure Of Information Relating To My Physical Or Mental Health. My Agent has the power and authority to do all of the following as long as it does not conflict with what I've said in this document, since it will help them get all the documentation and information they need to advocate for the care I want:

(a) Request, review, and receive any information, verbal or written, about my physical or mental health, including medical and hospital records;

(b) Sign on my behalf any releases or other documents that may be required in order to obtain this information; and

(c) Consent to the disclosure of this information.

I intend for my Agent to be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (a/k/a HIPAA), 42 USC 1320d and 45 C.F.R. 160-164. I authorize any physician, health-care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy or other covered health-care provider, any insurance company and the Medical Information Bureau Inc. or other health-care clearinghouse that has provided treatment or services to me, or that has paid for or is seeking payment from me for such services to give, disclose and release to my Agent, without restriction, all of my individually identifiable health information and medical records regarding any past, present or future medical or mental health conditions. The information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease.

3.2 Signing Documents, Waivers, And Releases. My Agent has the authority to sign the following to make sure I get the care that I have expressed I want in this document:

(a) Documents titled or purporting to be a "Refusal to Permit Treatment" and "Leaving Hospital Against Medical Advice," and

(b) Any necessary waiver or release from liability required by a hospital or physician.

3.3 Prior Designations Revoked. I revoke any Agent I have appointed in the past, or document I've signed that gives authority to make health care decisions to someone or something else.

3.4 Use of Photocopies Permitted. Persons dealing with my Agent may rely fully on a photocopy of this instrument as though the photocopy was an original.

PART IV

YOUR SIGNATURE **IS REQUIRED** ON THIS PAGE.

DATE AND YOUR SIGNATURE

I, _____ [name], sign my name to this Advance Health Care Directive on _____ [month, day], _____ [year], at _____ [city], Hawaii.

_____DRAFT_____
[your name]

To be legitimate, this advance health care directive MUST be witnessed by two competent witnesses or acknowledged by a notary public at any place within this State. For your protection, a witness may NOT be a person appointed as Agent by this advance directive, a health-care provider, or an employee of a health-care provider or facility. Additionally, at least one of the two witnesses may NOT be a person who is entitled to any portion of your estate under your will or codicil thereto existing at the time of the execution of this advance directive or by operation of law, or a person related to you by blood, marriage, or adoption.

SIGNATURES ARE REQUIRED **ON ONE OF THE TWO** FOLLOWING PAGES (p. 8-9)

[EITHER]

STATEMENT OF WITNESSES

I declare under penalty of perjury under the laws of Hawaii:

1) That I am 18 years of age or older;
2) That the individual (also referred to as "declarant") who signed this advance health care directive is personally known to me, or that the declarant's identity was proven to me and I believe him or her to be capable of making health care decisions;
3) That the declarant signed this advance directive in my presence;
4) That I am signing my name in the presence of declarant and at the declarant's direction or request;
5) That the declarant appears to be of sound mind and under no duress, fraud, or undue influence;
6) That I am not a person appointed as Health Care Agent by this advance directive or any other document, nor as an alternate Health Care Agent; and
7) That I am not a health-care provider or an employee of a health-care provider or facility.

Witness 1:

Signature: _____

Name: _____

Address: _____

Date: _____

Witness 2:

Signature: _____

Name: _____

Address: _____

Date: _____

ADDITIONAL STATEMENT OF WITNESSES

AT LEAST ONE OF THE ABOVE WITNESSES MUST ALSO SIGN THE FOLLOWING STATEMENT:

I further declare under penalty of perjury under the laws of Hawaii

1) That I am not related to the declarant executing this advance health care directive by blood, marriage, or adoption; and
2) To the best of my knowledge, I am not entitled to any part of the declarant's estate upon his or her death under a will now existing or by operation of law.

Signature: _____

Second Signature (optional): _____

[OR, if no qualified witnesses will be present, use the following acknowledgment by notary:]

ACKNOWLEDGMENT

State of Hawaii)
)
County of _____)

On this _____ day of _____, in the year _____, before me, _____ (insert name of notary public) appeared _____, personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this instrument, and acknowledged that he or she executed it.

I also state that I am not appointed as Health Care Agent or the declarant's attending or other physician, an employee of the attending physician or health care facility, a person who has a claim against any portion of declarant's estate, or a person who believes they are entitled to any portion of the declarant's estate as a beneficiary of declarant's will or an heir at law.

Place Notary Seal Below

_____
(SIGNATURE OF NOTARY)

_____
(PRINT NAME AND TITLE)

My commission expires:
_____