



This form may be used in the State of Alabama to make your wishes known about what medical treatment or other care you would or would not want if you become too sick to speak for yourself. You are not required to have an advance directive. If you do have an advance directive, be sure that your doctor, family, and friends know you have one and know where it is located.

## Section 1: Living Will

I, \_\_\_\_\_, being of sound mind and at least 19 years old, would like to make the following wishes known. I direct that my family, my doctors and health care workers, and all others follow the directions I am writing down. I know that at any time I can change my mind about these directions by tearing up this form and writing a new one. I can also do away with these directions by tearing them up and by telling someone at least 19 years of age my wishes and asking him or her to write them down. I understand that these directions will only be used if I am not able to speak for myself.

### **IF I BECOME TERMINALLY ILL OR INJURED:**

**Terminally ill or injured** is when my doctor and another doctor decide that I have a condition that cannot be cured and that I will likely die in the near future from this condition.

**Life sustaining treatment** – life sustaining treatment includes drugs, machines, or medical procedures that would keep me alive but would not cure me. I know that even if I choose not to have life sustaining treatment, I will still get medicines and treatments that **ease my pain and keep me comfortable**.

*Place your initials by either "yes" or "no":*

I want to have life sustaining treatment if I am terminally ill or injured. \_\_\_\_\_ Yes \_\_\_\_\_ No

**Artificially provided food and hydration** (food and water through a tube or an IV) – I understand that if I am terminally ill or injured I may need to be given food and water through a tube or an IV to keep me alive if I can no longer chew or swallow on my own or with someone helping me.

*Place your initials by either "yes" or "no":*

I want to have food and water provided through a tube or an IV if I am terminally ill or injured.  
\_\_\_\_\_ Yes \_\_\_\_\_ No

### **IF I BECOME PERMANENTLY UNCONSCIOUS:**

**Permanent unconsciousness** is when my doctor and another doctor agree that within a reasonable degree of medical certainty I can no longer think, feel anything, knowingly move, or be aware of being alive. They believe this condition will last indefinitely without hope for improvement and have watched me long enough to make that decision. I understand that at least one of these doctors must be qualified to make such a diagnosis.

**Life sustaining treatment** – life sustaining treatment includes drugs, machines, or medical procedures that would keep me alive but would not cure me. I know that even if I choose not to have life sustaining treatment, I will still get medicines and treatments that **ease my pain and keep me comfortable**.

*Place your initials by either "yes" or "no":*

I want to have life sustaining treatment if I am permanently unconscious. \_\_\_\_\_ Yes \_\_\_\_\_ No



**Artificially provided food and hydration** (food and water through a tube or an IV) – I understand that if I become permanently unconscious, I may need to be given food and water through a tube or an IV to keep me alive if I can no longer chew or swallow on my own or with someone helping me.

Place your initials by either "yes" or "no":

I want to have food and water provided through a tube or an IV if I am permanently unconscious.  
\_\_\_\_\_ Yes      \_\_\_\_\_ No

**OTHER DIRECTIONS:**

Please list any other things you want done or not done.

In addition to the directions I have listed on this form, I also want the following:

1. I direct that the person(s) I have appointed in Section 2 (Health Care Proxy) of this instrument shall have, in addition to those powers enumerated under this instrument, as defined in the Code of Alabama, Sections 22-8A-1 et. seq. and 26-1-2, the power: to act as surrogate for me for medical decisions; to act as my attorney-in-fact for the purpose of making medical, dental or mental health decisions of any kind that are authorized by any law of the State of Alabama; to access my medical, dental and mental health records; and to authorize any medical, dental or mental health procedures permitted by the laws of the State of Alabama. The powers of this paragraph shall be considered a durable power of attorney for medical care and shall not be affected by my disability, incompetency, or incapacity, and such rights, powers, and authority shall remain in full force and effect until my death, unless otherwise terminated by me in writing or by revocation of this instrument as defined by law. \_\_\_\_\_ (Initials)

2. The Health Care Proxy under this instrument is hereby designated as my "Personal Representative" as defined by 45 CFR 164.502, otherwise known as the Health Insurance Portability and Accountability Act of 1996, as amended, or HIPAA. This "Personal Representative" may view my medical records, execute releases of confidential information from medical providers and insurers or other third parties, and shall be considered my "Personal Representative" for health care disclosure under HIPAA. This authorization and consent to disclosure shall apply whether or not I continue to have the capacity to give informed consent, and is effective immediately upon signing of this Advance Health Care Directive. I further consent to and direct covered entities to provide my protected health information to my "Personal Representative" at any time upon his/her request. \_\_\_\_\_ (Initials)

If you do **not** have other directions, place your initials here: \_\_\_\_\_ No, I do **not** have any other directions.

3. \_\_\_\_\_  
\_\_\_\_\_

4. \_\_\_\_\_  
\_\_\_\_\_

**ORGAN/TISSUE DONATION:**

Place your initials by only one of the following:

\_\_\_\_\_ I do want to be an organ/tissue donor, if possible.  
\_\_\_\_\_ I do not want to be an organ/tissue donor.

## Section 2: If I Need Someone To Speak For Me (Health Care Proxy)

This form can be used in the State of Alabama to name a person to make medical or other decisions for you if you become too sick to speak for yourself. This person is called a health care proxy. You do not have to name a health care proxy. The directions in this form will be followed even if you do not name a health care proxy.

*Place your initials by only one answer:*

- I do not want to name a health care proxy. (If you check this answer, go to Section 3)
- I do want the person listed below to be my health care proxy. I have talked with this person about my wishes.

First choice for proxy: \_\_\_\_\_

Relationship to me: \_\_\_\_\_

Address: \_\_\_\_\_

Daytime telephone number: \_\_\_\_\_ Night-time phone number: \_\_\_\_\_

If this person is not able, not willing, or not available to be my health care proxy, this is my next choice:

Second choice for proxy: \_\_\_\_\_

Relationship to me: \_\_\_\_\_

Address: \_\_\_\_\_

Daytime telephone number: \_\_\_\_\_ Night-time phone number: \_\_\_\_\_

### Instructions for Proxy:

*Place your initials by either "yes" or "no":* I want my health care proxy to make decisions about whether to give me food and water through a tube or an IV.  Yes  No

*Place your initials by only one of the following:*

- I want my health care proxy to follow only the directions as listed on this form.
- I want my health care proxy to follow my directions as listed on this form and to make any decisions about things I have not covered in the form.
- I want my health care proxy to make the final decision, even though it could mean doing something different from what I have listed on this form.

## Section 3: The Things Listed On This Form Are What I Want

I understand the following:

If my doctor or hospital does not want to follow the directions I have listed, they must see that I get to a doctor or hospital who will follow my directions.

If I am pregnant, or if I become pregnant, the choices I have made on this form will not be followed until after the birth of the baby.

If the time comes for me to stop receiving life sustaining treatment or food and water through a tube or an IV, I direct that my doctor talk about the good and bad points of doing this, along with my wishes, with my health care proxy, if I have one, and with the following people: \_\_\_\_\_



## Section 4: My Signature

Print Your Name: \_\_\_\_\_ Month, Day and Year of Birth: \_\_\_\_\_

Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

## Section 5: Witnesses (Need Two Witnesses To Sign)

I am witnessing this form because I believe this person to be of sound mind. I did not sign the person's signature, and I am not the health care proxy. I am not related to the person by blood, adoption, or marriage and not entitled to any part of his or her estate. I am at least 19 years of age and am not directly responsible for paying for his or her medical care.

Print Name of First Witness: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name of Second Witness: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Section 6: Signature of Proxy

I, \_\_\_\_\_, am willing to serve as the health care proxy.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Second Choice for Proxy:

I, \_\_\_\_\_, am willing to serve as the health care proxy if the first choice cannot serve.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_