

Overview

Adults have the right to make choices about their health care. No treatments may be given to you if you do not want them.

The attached Durable Power of Attorney for Health Care form is a legal health care directive document, developed to meet the requirements of Iowa Code Chapters 144A and 144B. It allows you to appoint another person and alternate persons to make your health care decisions if you become unable. The person you ask to make health care choices for you is your **health care agent**.

This document gives your agent the authority to make health care decisions for you only if:

- **you are unable to communicate your wishes and health care decisions due to illness or injury, and**
- **health care providers have determined that you are not able to make your own health care decisions.**

This form does not give your agent permission to make your financial or other business decisions. As stated by Iowa law, “health care” means any care, treatment, service, or procedures to maintain, diagnose, or treat your physical or mental condition.

Take the time to read this form carefully before you complete it. You can list in this form the types of health care you do and do not want. You can limit the types of choices your health care agent can make. It is very important that you discuss your views, values, and this document with your health care agent. If you do not closely involve your agent, your views and values may not be fully respected because they may not be understood.

What if I decide not to complete a Durable Power of Attorney for Health Care form?

You do not have to sign a Durable Power of Attorney for Health Care form. Doctors, insurance providers, or non-profit hospitals cannot force you to have this type of form to receive their services. Under Iowa Code Chapter 144B, your life insurance cannot be canceled if your health care is being withdrawn or withheld according to your wishes in this form.

Initials _____
Date _____

While you have a choice not to complete this document, you should know that others may have to make health care decisions for you at some point in the future. Without knowing your wishes, these decisions can be very difficult for other people to make. Completing this document can help you talk to your circle of support about what is important to you and can help them make decisions that match your goals and values.

What if I decide to cancel my Durable Power of Attorney for Health Care form?

You have the right to cancel your Durable Power of Attorney Health Care form at any time. You can do this by informing your health care agent in person or in writing. You may also inform your health care provider. They will write down that you canceled this form in your medical record. You should also inform any other person to whom you have given a copy. Your current and valid form will cancel out any older versions. If your spouse is your health care agent, and you get divorced, the power granted to your spouse by this form is revoked. If you would remarry your spouse, this power is reinstated unless you cancel it.

Who should I choose to be my Health Care Agent?

A family member or friend who:

- Is at least 18 years old
- Knows you well
- Can be there for you when you need them
- Is willing to learn about your goals and values for health care decisions
- You trust will do what is best for you, and will follow your wishes
- Can make decisions under sometimes stressful situations

What kind of choices can my Health Care Agent make?

They can decide:

- Which doctors, nurses, or social workers may provide care to you
- Which hospitals or clinics will treat your conditions
- The types of medicines, immunizations/vaccinations, tests, or treatments you could get

Initials _____
Date _____



Durable Power of Attorney for Health Care Decisions

I, _____, (date of birth) _____,

select as my **Health Care Agent**:

Name: _____

Home: _____ Cell: _____ Work: _____

Address: _____

and give to my agent the power to make health care decisions for me. This power exists only when I am unable, in the judgment of my attending doctor, to make those health care decisions. My Health Care Agent must act consistently with my desires as stated in this document or otherwise made known.

If the first person cannot be my Health Care Agent, I then select the following person to be my **alternate Health Care Agent**:

Name: _____

Home: _____ Cell: _____ Work : _____

Address: _____

I understand that my Health Care Agent:

- will make choices for me **only** after I cannot make my own choices in the judgment of my doctor.
- can tell my doctor to stop giving me health care, even if it is needed to keep me alive.
- can make decisions regarding immunizations and vaccinations.
- can choose my health care providers, including hospitals, doctors, and end-of-life care.
- can look at my medical records and share my health care information as needed.
- can sign releases or other forms about my medical treatment.
- can decide if I should join a research study.

I now **cancel** all prior Durable Powers Of Attorney for Health Care Decisions.

Initials _____

Date _____

Consent for My Health Care Agent to Act as My Personal Representative and Consent for Release of Protected Health Information

I give permission for my Health Care Agent to act as my personal representative for purposes of the Health Insurance Portability and Accountability Act (HIPAA) of 1996. This includes amendments to HIPAA during any time that my Health Care Agent is acting on my behalf.

I give my Health Care Agent permission to ask for, receive, or look at any information about my physical or mental health. I approve that any health care provider, health plan, hospital, clinic, laboratory, pharmacy, insurance company, or other health care related business can share my personal health information and medical records with my Health Care Agent. This includes any past, present or future medical or mental illness regarding my ability to make health care choices. This permission includes information protected by HIPAA.

I understand my Health Care Agent can sign authorizations, releases, or other records that may be needed to get this information. My Health Care Agent can also consent for the release of my information to others. I understand that my Health Care Agent may share this information with others. This means that my information is no longer protected by HIPAA.

I also have the right to look at any information shared with my Health Care Agent.

I will mark with my initials the information that my Health Care Agent **cannot** have access to:

- Alcohol, drug, and other drug abuse
- Behavioral and mental health
- Sexually transmitted diseases, AIDS, and HIV-related information
- Genetic tests

I understand my Health Care Agent's access to my personal health information by this form terminates when I die. I can cancel this permission and consent at any time by sending a letter to my health care provider.

X _____ / _____ / _____
Sign your name Date

Print your name

Initials _____
Date _____

People Who My Health Care Agent Should Include in Decision-Making Steps

I ask that my health care agent make an effort to include these persons in my health care decisions:

Religion / Faith:

I am of the _____ faith, and am a part of the _____ community. Contact person and phone number of faith community: _____. I ask that my health care agent call my faith-based group.

List of Desires, Special Provisions, or Limits

The following are specific instructions for my health care agent and/or doctor providing my health care. If I need treatment in a state that does not accept this Durable Power of Attorney for Health Care, or my health care agent cannot be contacted, I want the instructions below to be followed based on common law and my legal right to direct my own health care.

Instructions for Filling in This Part

You do not have to give any written instructions or make any selections in this section. If you choose not to give any instructions, your health care agent will make choices based on:

- Your verbal instructions
- What is felt to be in your best interest

If you choose not to give any instructions, draw a line and write “no instructions” across the page. Place your initials before each statement that you want your health care agent, your doctor, and other health care providers to follow.

Initials _____
Date _____

Stopping Treatments to Prolong My Life

Life-support treatments are used to try and keep you alive.

If I reach a point where I can no longer make decisions for myself and it is reasonably certain that I will not recover my ability to know who I am (write initials on line if you agree):

_____ I want to **stop or withhold all treatments that are prolonging my life**. This includes but is not limited to tube feedings, IV (intravenous) fluids and medications, respirator/ventilator (breathing machine), dialysis, blood products and antibiotics.

Cardiopulmonary Resuscitation (CPR)

CPR is a treatment used to attempt to restore heart rhythm and breathing when they have stopped. It may include chest compressions, medicines, electrical shocks, and a breathing tube. I understand that CPR can save a life. I also understand that it does not work as well for people who have chronic (long-term) health problems and/or an illness that can no longer be treated.

My CPR choice listed below may be reconsidered by my health care agent in light of my other instructions or new medical information. My health care agent may act on my behalf if I cannot make my own choices.

If I do not want CPR tried, my doctor should be told about my choice. If I show below that I do not want CPR, I understand this choice alone will not stop emergency workers from attempting CPR in an emergency. Other papers may be needed to control the actions of emergency workers.

Select one option. Mark with your initials.

_____ I want CPR attempted if my heart stops or if I stop breathing.

OR

_____ I want CPR attempted if my heart stops or if I stop breathing unless my doctor decides any one of the following:

- I have an untreatable illness or injury and am dying; OR
- I have little chance of surviving; OR
- I have little chance of living much longer and the process of CPR would cause me significant suffering.

OR

_____ I do not want CPR attempted if my heart stops or if I stop breathing. Rather, I want my death to occur naturally.

Initials _____
Date _____

Treatment Choices

I understand that I will continue to be offered pain medicine and food and fluids by mouth if I am able to swallow. I have the following additional requests that I want my health care team and health care agent to know:

My Wishes

The things that make life most worth living to me are:

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

My thoughts and feelings about where I would like to die:

Additional information that I'd like my family and friends to know:

Initials _____
Date _____

After I Die

Organ donation (Mark with your initials):

___ I **want** to donate my organs, tissues, and eyes if able. My specific wishes (if any) are:

___ I am registered with the Iowa Donor Network.

___ My driver's license is marked "Y" for "yes".

___ I **do not want** to donate my organs, tissues or eyes.

Autopsy (Mark with your initials):

An autopsy can be done after death to find out why someone died (Organs, tissues and eyes may still be donated if an autopsy occurs). Sometimes an autopsy may be required by law to find out cause of death.

___ I **want** an autopsy.

___ I **want an autopsy if my family or health care agent wishes for an autopsy to be performed.**

___ I **do not want** an autopsy.

Body Donation:

A different option is to donate your body. These arrangements must be made **before** your death. If you wish to donate your body after death to medical science, please call a school listed below.

- University of Iowa, Department of Anatomy and Cell Biology (319) 335-7762
- Palmer College of Chiropractic in Davenport (563) 884-5000
- Osteopathic School of Medicine in Des Moines (515) 271-1400

___ I have registered my body to be donated to _____

Initials _____
Date _____

Celebration of Life and How My Body Should Be Treated

My wishes for a funeral/memorial/burial or other ceremonies after my death include:

Preferred funeral home or cremation service: _____

I would like to include, if possible, the following (people, readings, music, rituals, etc.):

Initials _____
Date _____

In order for this form to be valid, it must be acknowledged or witnessed in one of the following ways:

- It must be signed by you in the presence of a notary public in Iowa.

OR

- It must be signed by two witnesses. You and your two witnesses must all be present when the document is signed. If you are physically unable to sign this document, you can ask another person to sign it for you in your presence and in the presence of your witnesses.

If you choose to use witnesses, they must:

- Be at least 18 years old
- Watch you sign this form
- Watch the other witness sign this form

Your witnesses cannot:

- Be your health care agent or alternate health care agent
- Be your health care provider attending to you on the date that this form is signed
- Work for your health care provider

Also, one witness cannot:

- Be related to you by blood, marriage, or adoption

Sign your name at the X and write the date below:

X _____ / _____ / _____
 Sign your name Date

Print your name

 Address City State Zip Code

Initials _____
 Date _____

Notary Public

State of _____) County of _____)

This form was acknowledged before me on _____ (date)

by _____
Name of Person

Signature of Notary Public

Seal/Stamp
OR

Witnesses

By signing, I affirm that _____, and the other witness listed, signed this form while I watched. I also affirm that:

- I know them or they could prove who they are
- I am 18 years or older
- I am not their Health Care Agent
- I am not their health care provider
- I do not work for their health care provider

One witness must also affirm that:

- I am not related to them by blood, marriage, or adoption

Witness #1 (Sign your name at the X and write the date below):

X _____ / _____ / _____
Sign your name Date

Print your name

Address City State Zip Code

Witness #2 (Sign your name at the X and write the date below):

X _____ / _____ / _____
Sign your name Date

Print your name

Address City State Zip Code

Initials _____
Date _____

What do I do with the form after I fill it out?

When you have completed your health care directive, you should:

- Tell the person you named as your health care agent if you haven't already done so. Make sure that the person feels able to perform this important job for you in the future.
- Make copies:
 - ✓ one copy for yourself
 - ✓ one copy for your health care agent and any alternates
 - ✓ one copy to share and discuss with your doctor or other health care providers
 - ✓ one copy for the hospital where you have been treated or would go in an emergency
 - ✓ extra copies to share with others (friends, family, clergy, attorney)

A copy of this document is as legally valid as the original.

Copies of this document will be given or have been given to:

1. _____

2. _____

3. _____

4. _____

5. _____

Initials _____

Date _____

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