# STATE OF LOUISIANA

# DECLARATION

Declaration made this_____day of_____,_____(month, year).

I,_____, being of sound mind, willfully and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below and do hereby declare:

If at any time I should have an incurable injury, disease or illness, or be in a continual profound comatose state with no reasonable chance of recovery, certified to be a terminal and irreversible condition by two physicians who have personally examined me, one of whom shall be my attending physician, and the physicians have determined that my death will occur whether or not life-sustaining procedures are utilized and where the application of life-sustaining procedure would serve only to prolong artificially the dying process, I direct (initial one only):

_____ That all life-sustaining procedures, including nutrition and hydration, be withheld or withdrawn so that food and water will not be administered invasively.

_____ That life-sustaining procedures, except nutrition and hydration, be withheld or withdrawn so that food and water can be administered invasively.

I further direct that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care.

In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this declaration shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

I understand the full import of this declaration and I am emotionally and mentally competent to make this declaration.

Signed _____

City, Parish, and State of Residence_____

The declarant has been personally known to me and I believe him or her to be of sound mind.

Witness_____ Witness_____

**"LIVING WILL" DECLARATION**

(R.S. 40:1151 et. sec.)

**INSTRUCTIONS**: Per R.S. 40:1151 et. sec., the Secretary of State's Office has established a registry in which a person, or his attorney, if authorized by the person to do so, may register the original, multiple original, or a certified copy of the declaration. The filing fee is $20.00 to register the Declaration and receive a laminated identification card and ID bracelet. The filing fee for a revocation is $5.00. If a certified copy is requested from this office, there is an additional fee of $20.00 (per R.S. 49:222(A)). Mail the declaration, with the filing fee, to: Secretary of State, Attn: Elections Services, P.O. Box 94125, Baton Rouge, LA 70804-9125.

# LOUISIANA HEALTH CARE POWER OF ATTORNEY

1. I, , hereby appoint:

Name

Home Telephone Number

Home Address

Work Telephone Number

City, State

Cell Telephone Number

as my agent to make health-care decisions for me if I become unable to make my own health care decisions such as the following:

☐ A. Grant, refuse, or withdraw consent on my behalf for any health care service, treatment or procedure, even though my death may ensue.

☐ B. Talk to health care personnel, get information, have access to medical records and sign forms necessary to carry out these decisions.

☐ C. Authorize my admission to or discharge from any hospital, nursing home, residential care, assisted living or similar facility or service.

☐ D. Contract on my behalf for any health-care related services or facility (without my agent incurring personal financial liability for such contracts) such as surgery, medical expenses and prescriptions.

☐ E. Make decisions regarding surgery, medical expenses and prescriptions.

2. If the person named as my agent is not available or is unable to act as my agent, I appoint the following person(s) to serve in the order listed below:

A.

Name

Home Telephone Number

Home Address

Work Telephone Number

City, State

Cell Telephone Number

B.

Name

Home Telephone Number

Home Address

Work Telephone Number

City, State

Cell Telephone Number

3. With this document, I intend to create a durable power of attorney for health care, which shall take effect upon and only during any period in which, in the opinion of my attending physician, I am unable to make or communicate a choice regarding a particular health-care decision. My agent shall make health-care decisions as I direct below or as I make known to him/her in some other way. If my agent is unable to determine the choice I would want to make, then my agent shall make a choice for me based upon what my agent believes to be in my best interest.

4. With this document, I authorize any person, organization, or entity involved with my health care to disclose and release to my agent any and all of my individually identifiable health information and medical records in accordance with HIPAA.

5. **SPECIAL PROVISIONS AND LIMITATIONS.** I do NOT want the following treatments:

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6. To the extent that I am permitted by law to do so, I herewith nominate my agent to serve as the curator of my person, and/or in any similar representative capacity. If I am not permitted by law to make a nomination, then I request in the strongest possible terms that any court consider this nomination.

7. No person who relies in good faith upon representations by my agent or alternate agent shall be liable to me, my estate, my heirs or assigns for recognizing the agent's authority.

8. The powers delegated under this power of attorney are separable, so that the invalidity of one or more powers shall not affect any others.

**BY MY SIGNATURE I INDICATE THAT I UNDERSTAND THE PURPOSE AND EFFECT OF THIS DOCUMENT.**

I sign my name to this form on _____
(Date)

at: _____
(City, State)

_____
**(Signature)**

## WITNESSES

The person who signed or acknowledged this document is personally known to me and I believe him/her to be of sound mind.

*First Witness:*
Signature: _____

Home Address:

Print Name: Date: _____

*Second Witness:*
Signature: _____

Home Address:

Print Name: Date: _____

NOTARIZATION

STATE OF
PARISH OF

I, _____ a Notary Public in and for the State and Parish aforesaid, do hereby certify that _____ who personally came and appeared before me as the Principal, and executed the foregoing Durable Power of Attorney for Health-Care in said State and Parish, and acknowledged said Durable Power of Attorney for Health-Care as the Principal's voluntary act.

Witness my signature this _____ day of _____, 20___.

_____
NOTARY PUBLIC