Honoring My Care Decisions

Peace of Mind is Planning Ahead

Full Name: _____ Date of Birth: _____

Address _____ City: _____ State: _____ Zip code: _____

Phone#: _____ Phone#: _____ Email: _____

(Cell / Home / Work) (Cell / Home / Work)

Advance Directive/Declaration

I, _____, believe that my life deserves to be treated with dignity. I desire that my dying shall not be artificially prolonged under the circumstances set forth below.

If at any time:

1. I have an incurable injury, disease, or illness, or am in a continual, profound comatose state with no reasonable chance of recovery

AND

2. My doctor and one other doctor examine me and indicate that I have a terminal and irreversible condition and death will occur whether or not life-sustaining procedures are utilized, or life-sustaining procedures would serve only to artificially prolong the dying process, then, I direct the following instructions be followed.

Check one of the following:

____ That all life-sustaining procedures be withheld or withdrawn, **including** the provision of artificial nutrition and hydration. Focus on making me comfortable and allow natural death.

OR

____ That all life-sustaining procedures be withheld or withdrawn, **except** nutrition and hydration. If the invasive administration of nutrition and hydration is excessively burdensome as determined by my physician, Healthcare Power of Attorney, or other legal decision maker, it may be withdrawn.

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 Healthcare Power of Attorney, other legal decision maker, family and/or physician(s) as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

Under Louisiana Law, two witnesses must verify your signature and the date. These witnesses must be 18 years of age or older and not related by blood or marriage, nor stand to gain financially in the event of your death.

This document states my wishes about my future healthcare decisions.

_____	_____	_____
Your Signature	Print Your Name	Date

I certify that I am at 18 years of age or older and not related by blood or marriage, nor stand to gain financially in the event of the death of the person completing this document.

Witness 1 Signature

_____	_____	_____
Signature	Print Name	Date

Witness 2 Signature

_____	_____	_____
Signature	Print Name	Date

***Notarization of your Advance Directive Document is optional in Louisiana. ***

Honoring My Care Decisions

Peace of Mind is Planning Ahead

Full Name: _____ Date of Birth: _____

Address _____ City: _____ State: _____ Zip code: _____

Phone#: _____ Phone#: _____ Email: _____

(Cell / Home / Work) (Cell / Home / Work)

Healthcare Power of Attorney (Agent)

I _____, am a person of the full age of majority and a resident of the Parish of _____, State of Louisiana.

I appoint, name, and authorize the following, hereinafter referred to as "Agent," to be my agent(s) and attorney-in-fact, giving the Agent full power and authority to make healthcare and medical decisions on my behalf, including, but not limited to, healthcare and medical decisions related to surgeries and procedures; medical treatments; medical examinations/evaluations; medical tests; hospitalizations and other confinements to medical, healthcare and/or nursing home facilities; and administration of medications and prescription or other drugs or substances, but only to the extent such are recommended by a duly licensed physician. I waive any and all restrictions on access by my Agent(s) to my health records under the Health Insurance Portability and Accountability Act or other statute.

Primary Agent:

Name: _____ Relationship: _____

Phone#: _____ Phone#: _____ Email: _____

(Cell / Home / Work) (Cell / Home / Work)

Address _____ City: _____ State: _____ Zip code: _____

If the Primary Agent is not able or willing to make my healthcare decisions, then the following person is my next choice:

Secondary Agent: ___Not Applicable

Name: _____ Relationship: _____

Phone#: _____ Phone#: _____ Email: _____

(Cell / Home / Work) (Cell / Home / Work)

Address _____ City: _____ State: _____ Zip code: _____

This power of attorney shall not terminate upon my disability, infirmity, incompetence or incapacity, but rather it is my specific intention to authorize and direct my Agent(s) to carry out the power of attorney granted to my Agent(s) hereunder in such event, notwithstanding such disability, infirmity, incompetence or incapacity.

In the event that one of the Agents specified above dies or resigns as Agent, the remaining Agent shall have full authority to act.

_____	_____	_____
Your Signature	Print Your Name	Date

Witness 1 Signature

_____	_____	_____
Signature	Print Name	Date

Witness 2 Signature

_____	_____	_____
Signature	Print Name	Date

This HC POA document is valid once all three signatures lines above are complete.

Signature of Agent indicating acceptance of Healthcare Power of Attorney role (optional):

Primary Agent:

ACCEPTED: _____ DATE: _____
Primary Agent Signature

Secondary Agent:

ACCEPTED: _____ DATE: _____
Secondary Agent Signature