Maryland Advance Directive:

Planning for Future Health Care Decisions

PRINT YOUR NAME AND THE DATE

By: _____
(Print Name)

Date of Birth: _____
(Month/Day/Year)

Using this advance directive form to do health care planning is completely optional. Other forms are also valid in Maryland. No matter what form you use, talk to your family and others close to you about your wishes.

This form has two parts to state your wishes, and a third part for needed signatures. Part I of this form lets you answer this question: If you cannot (or do not want to) make your own health care decisions, who do you want to make them for you? The person you pick is called your health care agent. Make sure you talk to your health care agent (and any back-up agents) about this important role. Part II lets you write your preferences about efforts to extend your life in three situations: terminal condition, persistent vegetative state, and end-stage condition. In addition to your health care planning decisions, you can choose to become an organ donor after your death by filling out the form for that too.

You can fill out Parts I and II of this form, or only Part I, or only Part II. Use the form to reflect your wishes, then sign in front of two witnesses (Part III). If your wishes change, make a new advance directive.

Make sure you give a copy of the completed form to your health care agent, your doctor, and others who might need it. Keep a copy at home in a place where someone can get it if needed. Review what you have written periodically.

PART I: SELECTION OF HEALTH CARE AGENT

A. Selection of Primary Agent

I select the following individual as my agent to make health care decisions for me:

Name: _____

Address: _____

_____

Telephone Numbers: _____
(home and cell)

PRINT THE NAME, ADDRESS, AND TELEPHONE NUMBER(S) OF YOUR PRIMARY AGENT

B. Selection of Back-up Agents

(Optional; form valid if left blank)

1. If my primary agent cannot be contacted in time or for any reason is unavailable or unable or unwilling to act as my agent, then I select the following person to act in this capacity:

Name: _____

Address: _____

_____

Telephone Numbers: _____
(home and cell)

PRINT THE NAME, ADDRESS, AND TELEPHONE NUMBER(S) OF YOUR FIRST BACK-UP AGENT

2. If my primary agent and my first back-up agent cannot be contacted in time or for any reason are unavailable or unable or unwilling to act as my agent, then I select the following person to act in this capacity:

Name: _____

Address: _____

_____

Telephone Numbers: _____
(home and cell)

PRINT THE NAME, ADDRESS, AND TELEPHONE NUMBER(S) OF YOUR SECOND BACK-UP AGENT

C. Powers and Rights of Health Care Agent

I want my agent to have full power to make health care decisions for me, including the power to:

1. Consent or not consent to medical procedures and treatments which my doctors offer, including things that are intended to keep me alive, like ventilators and feeding tubes;

2. Decide who my doctor and other health care providers should be; and

3. Decide where I should be treated, including whether I should be in a hospital, nursing home, other medical care facility, or hospice program.

I also want my agent to:

1. Ride with me in an ambulance if ever I need to be rushed to the hospital; and

2. Be able to visit me if I am in a hospital or any other health care facility.

This advance directive does not make my agent responsible for any of the costs of my care.

This power is subject to the following conditions or limitations:

(Optional; form valid if left blank)

PRINT INSTRUCTIONS HERE ONLY IF YOU WANT TO LIMIT YOUR AGENT'S POWERS

D. How My Agent Is To Decide Specific Issues

I trust my agent's judgment. My agent should look first to see if there is anything in Part II of this advance directive, if I have filled out Part II, that helps decide the issue. Then, my agent should think about the conversations we have had, my religious or other beliefs and values, my personality, and how I handled medical and other important issues in the past. If what I would decide is still unclear, then my agent is to make decisions for me that my agent believes are in my best interest. In doing so, my agent should consider the benefits, burdens, and risks of the choices presented by my doctors.

E. People My Agent Should Consult

(Optional; form valid if left blank)

In making important decisions on my behalf, I encourage my agent to consult with the following people. By filling this in, I do not intend to limit the number of people with whom my agent might want to consult or my agent's power to make these decisions.

Name(s) Telephone Number(s):

PRINT THE NAMES AND TELEPHONE NUMBERS OF ANYONE YOU WANT YOUR AGENT TO CONSULT WITH IN MAKING DECISIONS FOR YOU

PRINT ANY INSTRUCTIONS IN THE EVENT YOU ARE PREGNANT WHEN A DECISION MUST BE MADE

F. In Case of Pregnancy

(Optional, for women of child-bearing years only; form valid if left blank)

If I am pregnant, my agent shall follow these specific instructions:

_____

_____

_____

_____

_____

_____

_____

_____

G. Access to My Health Information - Federal Privacy Law (HIPAA) Authorization

1. If, prior to the time the person selected as my agent has power to act under this document, my doctor wants to discuss with that person my capacity to make my own health care decisions, I authorize my doctor to disclose protected health information which relates to that issue.

2. Once my agent has full power to act under this document, my agent may request, receive, and review any information, oral or written, regarding my physical or mental health, including, but not limited to, medical and hospital records and other protected health information, and consent to disclosure of this information.

3. For all purposes related to this document, my agent is my personal representative under the Health Insurance Portability and Accountability Act (HIPAA). My agent may sign, as my personal representative, any release forms or other HIPAA-related materials.

H. Effectiveness of This Part

(Read both of these statements carefully. Then, initial one only.)

My agent's power is in effect:

INITIAL ONLY ONE

_____ 1. Immediately after I sign this document, subject to my right to make any decision about my health care if I want and am able to.

((or))

_____ 2. Whenever I am not able to make informed decisions about my health care, either because the doctor in charge of my care (attending physician) decides that I have lost this ability temporarily, or my attending physician and a consulting doctor agree that I have lost this ability permanently.

I. Waiver of Right to Revoke Appointment of Agent

INITIAL ONLY IF YOU WISH TO WAIVE YOUR RIGHT TO REVOKE THE APPOINTMENT OF YOUR AGENT IN THE EVENT YOU BECOME INCAPABLE OF MAKING AN INFORMED DECISION.

(Read this section carefully. Then, initial only if you wish to waive your right to revoke the appointment of your agent upon certification of incapacity.)

_____I wish to waive my ability to revoke the appointment of my agent during a period in which the doctor in charge of my care (attending physician) and a second physician certify in writing that I am incapable of making an informed decision. In the case that I am unconscious or unable to communicate by any means, the certification of a second physician is not required.

If the only thing you want to do is select a health care agent, skip Part II. Go to Part III to sign and have the advance directive witnessed. If you also want to write your treatment preferences, use Part II. Also consider becoming an organ donor, using the separate "After my Death" form for that.

PART II: TREATMENT PREFERENCES ("LIVING WILL")

A. Statement of Goals and Values

(Optional; form valid if left blank)

I want to say something about my goals and values, and especially what's most important to me during the last part of my life:

USE THIS SPACE TO DISCUSS YOUR ADVANCE PLANNING GOALS AND VALUES ATTACH ADDITIONAL PAGES IF NEEDED

_____

_____

_____

_____

(attach additional pages if needed)

B. Preference in Case of Terminal Condition

(If you want to state your preference, initial one only. If you do not want to state a preference here, cross through the whole section.)

INITIAL YOUR PREFERENCE IN THE EVENT YOU ARE IN A TERMINAL CONDITION

INITIAL ONLY ONE PREFERENCE

_____ 1. Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means.

((or))

_____ 2. Keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means.

((or))

_____ 3. Try to extend my life for as long as possible, using all available interventions that in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical means.

C. Preference in Case of Persistent Vegetative State

(If you want to state your preference, initial one only. If you do not want to state a preference here, cross through the whole section.)

If my doctors certify that I am in a persistent vegetative state, that is, if I am not conscious and am not aware of myself or my environment or able to interact with others, and there is no reasonable expectation that I will ever regain consciousness:

INITIAL YOUR PREFERENCE IN THE EVENT YOU ARE IN A PERSISTENT VEGETATIVE STATE

INITIAL ONLY ONE PREFERENCE

_____ 1. Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means.

((or))

_____ 2. Keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means.

((or))

_____ 3. Try to extend my life for as long as possible, using all available interventions that in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical means.

D. Preference in Case of End-Stage Condition

(If you want to state your preference, initial one only. If you do not want to state a preference here, cross through the whole section.)

If my doctors certify that I am in an end-stage condition, that is, an incurable condition that will continue in its course until death and that has already resulted in loss of capacity and complete physical dependency:

INITIAL YOUR PREFERENCE IN THE EVENT YOU DEVELOP AN END-STAGE CONDITION

INITIAL ONLY ONE PREFERENCE

_____1. Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means.

((or))

_____2. Keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means.

((or))

_____ 3. Try to extend my life for as long as possible, using all available interventions that in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical means.

ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

E. Additional Instructions:

(You may add additional instructions, if any, here. This section may be useful to you if you have crossed through the sections above, or if your concerns are not otherwise addressed by this form.)

F. Pain Relief

No matter what my condition, give me the medicine or other treatment I need to relieve pain.

G. In Case of Pregnancy

(Optional, for women of child-bearing years only; form valid if left blank)

ADD INSTRUCTIONS HERE IF YOU WANT DIFFERENT TREATMENT IN THE EVENT YOU ARE PREGNANT

If I am pregnant, my decision concerning life-sustaining procedures shall be modified as follows:

_____

_____

_____

_____

_____

_____

H. Effect of Stated Preferences

INITIAL ONLY ONE, DEPENDING ON HOW STRICTLY YOU WANT YOUR TREATMENT PREFERENCES FOLLOWED

(Read both of these statements carefully. Then, initial one only.)

_____1. I realize I cannot foresee everything that might happen after I can no longer decide for myself. My stated preferences are meant to guide whoever is making decisions on my behalf and my health care providers, but I authorize them to be flexible in applying these statements if they feel that doing so would be in my best interest.

((or))

_____ 2. I realize I cannot foresee everything that might happen after I can no longer decide for myself. Still, I want whoever is making decisions on my behalf and my health care providers to follow my stated preferences exactly as written, even if they think that some alternative is better.

I. Waiver of Right to Revoke Treatment Preferences ("Living Will")

(Read this section carefully. Then, initial only if you wish to waive your right to revoke your stated treatment preferences upon certification of incapacity.)

INITIAL ONLY IF YOU WISH TO WAIVE YOUR RIGHT TO REVOKE YOUR STATED TREATMENT PREFERENCES IN THE EVENT YOU BECOME INCAPABLE OF MAKING AN INFORMED DECISION.

_____I wish to waive my ability to revoke my stated treatment preferences ("Living Will") during a period in which the doctor in charge of my care (attending physician) and a second physician certify in writing that I am incapable of making an informed decision. In the case that I am unconscious or unable to communicate by any means, the certification of a second physician is not required.

PART III: SIGNATURE AND WITNESSES

By signing below as the Declarant, I indicate that I am emotionally and mentally competent to make this advance directive and that I understand its purpose and effect. I also understand that this document replaces any similar advance directive I may have completed before this date.

SIGN AND DATE YOUR DOCUMENT

_____

(Signature of Declarant) (Date)

The declarant signed or acknowledged signing this document in my presence and, based upon personal observation, appears to be emotionally and mentally competent to make this advance directive.

YOUR WITNESSES MUST SIGN AND DATE AND LIST THEIR TELEPHONE NUMBERS HERE

_____

(Signature of Witness) (Date)

Telephone Number(s): _____

_____

(Signature of Witness) (Date)

Telephone Number(s): _____

ONE WITNESS MUST NOT KNOWINGLY INHERIT ANYTHING FROM YOU OR OTHERWISE KNOWLINGLY BENEFIT FROM YOUR DEATH

(Note: Anyone selected as a health care agent in Part I may not be a witness. Also, at least one of the witnesses must be someone who will not knowingly inherit anything from the declarant or otherwise knowingly gain a financial benefit from the declarant's death. Maryland law does not require this document to be notarized.)

MARYLAND "AFTER MY DEATH" FORM – PAGE 1 OF 3

AFTER MY DEATH

(This form is optional. Fill out only what reflects your wishes.)

By: _____
(Print Name)

Date of Birth: _____
(Month/Day/Year)

PART I: ORGAN DONATION

(Initial the ones that you want.)

Upon my death I wish to donate:

INITIAL ONLY ONE

_____Any needed organs, tissues, or eyes.
_____ Only the following organs, tissues, or eyes:

_____
_____

I authorize the use of my organs, tissues, or eyes:

INITIAL ALL THAT APPLY

_____ For transplantation
_____ For therapy
_____ For research
_____ For medical education
_____ For any purpose authorized by law

I understand that no vital organ, tissue, or eye may be removed for transplantation until after I have been pronounced dead under legal standards. This document is not intended to change anything about my health care while I am still alive. After death, I authorize any appropriate support measures to maintain the viability for transplantation of my organs, tissues, and eyes until organ, tissue, and eye recovery has been completed. I understand that my estate will not be charged for any costs related to this donation.

PART II: DONATION OF BODY

INITIAL HERE IF YOU WANT YOUR BODY DONATED FOR MEDICAL STUDY

_____ After any organ donation indicated in Part I, I wish my body to be donated for use in a medical study program.

PART III: DISPOSITION OF BODY AND FUNERAL ARRANGEMENTS

I want the following person to make decisions about the disposition of my body and my funeral arrangements:

(Either initial the first or fill in the second.)

INITIAL ONLY ONE

_____ The health care agent who I named in my advance directive.

((or))

_____ This person:

PRINT NAME, ADDRESS, AND TELEPHONE NUMBER OF THE PERSON YOU WANT TO MAKE DECISIONS REGARDING DISPOSITION OF YOUR BODY

Name: _____

Address: _____

_____

_____

Telephone Numbers: _____
(home and cell)

If I have written my wishes below, they should be followed. If not, the person I have named should decide based on conversations we have had, my religious or other beliefs and values, my personality, and how I reacted to other peoples' funeral arrangements. My wishes about the disposition of my body and my funeral arrangements are:

PRINT ADDITIONAL INSTRUCTIONS HERE, IF ANY

_____

_____

_____

_____

MARYLAND "AFTER MY DEATH" FORM – PAGE 3 OF 3

PART IV: SIGNATURE AND WITNESSES

By signing below, I indicate that I am emotionally and mentally competent to make this donation and that I understand the purpose and effect of this document.

SIGN AND DATE YOUR DOCUMENT HERE

_____

(Signature of Donor) (Date)

The Donor signed or acknowledged signing this donation document in my presence and, based upon personal observation, appears to be emotionally and mentally competent to make this donation.

HERE YOUR WITNESSES SIGN AND DATE AND PRINT THEIR TELEPHONE NUMBERS HERE

_____

(Signature of Witness) (Date)

Telephone Number(s) _____

_____

(Signature of Witness) (Date)

Telephone Number(s) _____

Courtesy of Caring Info
1731 King St, Suite 100, Alexandria, VA 22314
www.caringinfo.org, 800/658-8898