ADVANCE HEALTH CARE DIRECTIVE
CALIFORNIA POWER OF ATTORNEY FOR HEALTH CARE
(Appointing an Agent to Make Health Care Decisions)

NOTE: COMPLETION OF THIS FORM IS ONLY THE FIRST STEP. YOU SHOULD DISCUSS YOUR WISHES IN DETAIL WITH YOUR DESIGNATED AGENT(S).

My name is: ____

My address is: ____

In this document, I appoint one or more agents to make health care decisions for me. **My agent's authority shall begin immediately, even though I currently have the mental capacity to make my own health care decisions.**

The following persons **cannot be selected** as your agent or alternate agent:
- Your primary physician.
- The operator of a community care facility or residential care facility where you receive care.
- An employee of the health care institution, community care facility or residential care facility where you receive care (unless you are related to that person, the person is your registered domestic partner, or you and the person are employed by the same facility or institution).

AGENT

Name: ______________________________

Address: ______________________________

____

Home Phone: ______________________
Work Phone: ______________________

1ST ALTERNATE AGENT (If Agent is unavailable or unwilling to serve.)

Name: ______________________________

Address: ______________________

____

Home Phone: ______________________
Work Phone: ______________________

2ND ALTERNATE AGENT (If Agent and 1ST Alternate are unavailable or unwilling to serve.)

Name: ______________________________

Address: ______________________________

____

Home Phone: ______________________
Work Phone: ______________________

AGENT'S AUTHORITY
Except as limited by this document, my agent will have authority to make health care decisions for me to the extent that I now have authority to make my own health care decisions. This authority includes, but is not limited to, the authority 1) to accept or refuse treatment, nutrition and hydration, 2) to choose a particular physician or health care facility, and 3) to receive, or consent to the release of, medical information and records. **If I have the mental capacity to make my own health care decisions, my agent shall not have the authority to make any health care decision with which I disagree.**

Except as limited by this document, this authority includes the authority to authorize an autopsy, donate all or part of my body, and/or direct the disposition of my remains.

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AGENT'S DUTIES

My agent shall make decisions for me in accordance with this power of attorney for health care, any written instructions I have provided to my agent and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

HEALTH CARE INSTRUCTIONS (OPTIONAL)

I make the following instructions to my agent:

____

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(Attach additional pages if necessary. Sign and date any additional pages on the same day you sign this document, and state the number of attached pages here: _____.)

AUTHORITY UNDER HIPAA AND CMIA

My agent shall be a personal representative of mine under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). As such, my agent has the same rights to inspect and obtain copies of any medical or other health information as I would have. My agent also has the right to authorize disclosure of my patient records and other medical or health information subject to and protected under HIPAA. Pursuant to the California Confidentiality of Medical Information Act (CMIA) and Section 4678 of the California Probate Code, my agent has the same rights to request, receive, examine, copy and consent to the disclosure of my medical or other health care information as I would have.

The above authority applies to any individually identifiable health or medical information, health care information or other medical records governed by HIPAA, CMIA or Section 4678 of the California Probate Code.

PERSONAL CARE DECISIONS

I authorize my agent to make decisions regarding my personal care including, but not limited to, determining where I will live, providing meals, hiring household employees, providing transportation, handling mail, and arranging recreation and entertainment. If I initial here ______, I do not want my agent to have the authority provided by the immediately preceding sentence.

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DISAGREEMENT WITH OTHER AGENTS

In case of disagreement between my agent and an agent under any financial or other power of attorney of mine regarding payment for my health and/or personal care or regarding any other matters addressed under this power of attorney for health care, the decision of my agent under this power of attorney for health care shall control. If I initial here ______, I do not want my agent to have the authority provided by the immediately preceding sentence.

REVOCATION OF PREVIOUS DOCUMENTS

I revoke any previously-executed Power of Attorney for Health Care, Individual Health Care Instruction or Natural Death Act Declaration.

SIGNATURE OF PRINCIPAL (PERSON APPOINTING THE AGENT)

Date: ____________________ Signature: ____

(If principal is not physically able to sign, he or she can instruct another person to sign the principal's name, if signature is done in the principal's presence.)

WITNESSES

This document must either be notarized or signed by two adult witnesses. If the principal (the person appointing the agent) currently resides in a nursing facility, this document also must be witnessed by a patient advocate or ombudsman designated by the California Department of Aging. If the two-witness method is chosen, the patient advocate or ombudsman may serve as one of the two witnesses, or may serve as a third witness. If the notarization method is chosen, the patient advocate or ombudsman serves as a separate witness.

Certain individuals cannot serve as witnesses. Those rules are set forth in the following witness statements.

I declare under penalty of perjury under the laws of California

(1) that the individual who signed or acknowledged this advance health care directive is personally known to me, or that the individual's identity was proven to me by convincing evidence,
(2) that the individual signed or acknowledged this advance directive in my presence,
(3) that the individual appears to be of sound mind and under no duress, fraud, or undue influence,
(4) that I am not a person appointed as agent by this advance directive, and
(5) that I am not the individual's health care provider, an employee of the individual's health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility for the elderly, nor an employee of an operator of a residential care facility for the elderly.

First Witness: ______________________________ ____

Name (printed) Signature

Date: __________________ Address: ____

Second Witness: ______________________________ ____

Name (printed) Signature

Date: _________________ Address: ____

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ONE OF THE PRECEDING WITNESSES ALSO MUST SIGN THE FOLLOWING DECLARATION:
I further declare under penalty of perjury under the laws of California that I am not related to the individual executing this advance health care directive by blood, marriage, or adoption, and to the best of my knowledge, I am not entitled to any part of the individual's estate upon his or her death under a will now existing or by operation of law.

Date: ________________ Signature: ____

STATEMENT OF PATIENT ADVOCATE OR OMBUDSMAN
(Required if person appointing the agent currently resides in a nursing facility)
I declare under penalty of perjury under the laws of California that I am a patient advocate or ombudsman designated by the State Department of Aging and that I am serving as a witness as required by Section 4675 of the Probate Code.

Date: ________________ Signature: ____
Printed Name of Advocate or Ombudsman: ____
Address: ____
City, State: ____

ACKNOWLEDGMENT OF NOTARY PUBLIC (Not required if two-witness method is followed)

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California
County of ____________________

On ______________________________________, before me, ______________________________________, a

Notary Public in and for said State, personally appeared ______________________________________, who proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her authorized capacity, and that by his/her/their signature on the instrument the person executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____________________________________ (Seal)

NOTE: USE OF THIS FORM IS NOT APPROPRIATE FOR EVERY PERSON OR EVERY SITUATION. FOR MORE INFORMATION ABOUT POWERS OF ATTORNEY FOR HEALTH CARE, CONSULT WITH AN ATTORNEY.

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