**ADVANCE DIRECTIVE FOR HEALTHCARE**

**OF CLIENT**

**This document is HIPAA compliant.**

If I, **CLIENT**,am incapable of making an informed decision regarding my healthcare, I direct my healthcare providers to follow my instructions below.

**I. LIVING WILL**

If my attending physician and another physician determine that I am no longer able to make decisions regarding my medical treatment, I direct my attending physician and other healthcare providers, pursuant to the Oklahoma Advance Directive Act, to follow my instructions as set forth below:

**(1)** If I have a terminal condition, that is, an incurable and irreversible condition that even with the administration of life-sustaining treatment will, in the opinion of the attending physician and another physician, result in death within six (6) months:

(Initial only one option)

\_\_\_\_\_\_ I direct that my life not be extended by life-sustaining treatment, except that if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

\_\_\_\_\_\_ I direct that my life not be extended by life-sustaining treatment, including artificially administered nutrition and hydration.

\_\_\_\_\_\_ I direct that I be given life-sustaining treatment and, if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

\_\_\_\_\_\_ See my more specific instructions in paragraph (4) below. (Initial if applicable)

**(2)** If I am persistently unconscious, that is, I have an irreversible condition, as determined by the attending physician and another physician, in which thought and awareness of self and environment are absent:

(Initial only one option)

\_\_\_\_\_\_ I direct that my life not be extended by life-sustaining treatment, except that if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

\_\_\_\_\_\_ I direct that my life not be extended by life-sustaining treatment, including artificially administered nutrition and hydration.

\_\_\_\_\_\_ I direct that I be given life-sustaining treatment and, if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

\_\_\_\_\_\_ See my more specific instructions in paragraph (4) below. (Initial if applicable)

**(3)** If I have an end-stage condition, that is, a condition caused by injury, disease, or illness, which results in severe and permanent deterioration indicated by incompetency and complete physical dependency for which treatment of the irreversible condition would be medically ineffective:

(Initial only one option)

\_\_\_\_\_\_ I direct that my life not be extended by life-sustaining treatment, except that if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

\_\_\_\_\_\_ I direct that my life not be extended by life-sustaining treatment, including artificially administered nutrition and hydration.

\_\_\_\_\_\_ I direct that I be given life-sustaining treatment and, if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

\_\_\_\_\_\_ See my more specific instructions in paragraph (4) below. (Initial if applicable)

**(4)** OTHER. Here you may:

**(a)** describe other conditions in which you would want life-sustaining treatment or artificially administered nutrition and hydration provided, withheld, or withdrawn,

**(b)** give more specific instructions about your wishes concerning life-sustaining treatment or artificially administered nutrition and hydration if you have a terminal condition, are persistently unconscious, or have an end-stage condition, or

**(c)** do both of these:

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\_\_\_\_\_\_\_ (Initial)

**II. MY APPOINTMENT OF MY HEALTHCARE PROXY**

a. If my attending physician and another physician determine that I am no longer able to make decisions regarding my medical treatment, I direct my attending physician and other healthcare providers pursuant to the Oklahoma Advance Directive Act to follow the instructions of **FIDUCIARY1** of City, State, whom I appoint as my healthcare proxy. If my healthcare proxy is unable or unwilling to serve, I appoint the following individuals and entity in the order named to serve as my alternate healthcare proxy with the same authority, as his/her/their predecessor becomes unable to serve: **FIDUCIARY2** of City, State; **FIDUCIARY3** of City, State. My healthcare proxy is authorized to make whatever medical treatment decisions I could make if I were able, except that decisions regarding life-sustaining treatment and artificially administered nutrition and hydration can be made by my healthcare proxy or alternate healthcare proxy only as I have indicated in the foregoing sections.

If I fail to designate a healthcare proxy in this section, I am deliberately declining to designate a healthcare proxy.

b. I intend by this appointment of my healthcare proxy to designate the individual or individuals who shall have authority to act on my behalf in making decisions related to my healthcare. In exercising such authority, my healthcare proxy shall constitute my “personal representative” for all purposes of the Health Insurance Portability and Accountability Act of 1996 and its regulations (“HIPAA”) immediately upon my signing this document. Pursuant to HIPAA, I specifically authorize my healthcare proxy as my HIPAA personal representative to request, receive and review any information regarding my physical or mental health, including, without limitation all HIPAA protected health information, medical and hospital records; to execute on my behalf any authorizations, releases or other documents that may be required in order to obtain this information; and to consent to the disclosure of this information. I further authorize my healthcare proxy to execute on my behalf valid authorizations for the release of HIPAA protected health information. By signing this Advanced Directive for Healthcare, I specifically empower and authorize my physician, hospital or healthcare provider to release any and all medical records to my healthcare proxy or any person designated in a valid authorization for the release of HIPAA protected health information executed by my healthcare proxy. Further, I waive any liability to any physician, hospital or any healthcare provider who releases any and all of my medical records to my healthcare proxy and acknowledge that the health information that would otherwise be protected under HIPAA will no longer be protected or private with respect to my healthcare proxy.

**III. ANATOMICAL GIFTS**

Pursuant to the provisions of the Uniform Anatomical Gift Act, I direct that at the time of my death my entire body or designated body organs or body parts be donated for purposes of:

(Initial all that apply)

\_\_\_\_\_\_ transplantation

\_\_\_\_\_\_ therapy

\_\_\_\_\_\_ advancement of medical science, research, or education

\_\_\_\_\_\_ advancement of dental science, research, or education

Death means either irreversible cessation of circulatory and respiratory functions or irreversible cessation of all functions of the entire brain, including the brain stem. If I initial the “yes” line below, I specifically donate:

\_\_\_\_\_\_ My entire body

or

\_\_\_\_\_\_ The following body organs or parts:

\_\_\_\_\_\_ lungs \_\_\_\_\_\_ liver

\_\_\_\_\_\_ pancreas \_\_\_\_\_\_ heart

\_\_\_\_\_\_ kidneys \_\_\_\_\_\_ brain

\_\_\_\_\_\_ skin \_\_\_\_\_\_ bones/marrow

\_\_\_\_\_\_ blood/fluids \_\_\_\_\_\_ tissue

\_\_\_\_\_\_ arteries \_\_\_\_\_\_ eyes/cornea/lens

**IV. GENERAL PROVISIONS**

1. I understand that I must be eighteen (18) years of age or older to execute this form.
2. I understand that my witnesses must be eighteen (18) years of age or older and shall not be related to me and shall not inherit from me.
3. I understand that if I have been diagnosed as pregnant and that diagnosis is known to my attending physician, I will be provided with life-sustaining treatment and artificially administered hydration and nutrition unless I have, in my own words, specifically authorized that during a course of pregnancy, life-sustaining treatment and/or artificially administered hydration and/or nutrition shall be withheld or withdrawn.
4. In the absence of my ability to give directions regarding the use of life-sustaining procedures, it is my intention that this advance directive shall be honored by my family and physicians as the final expression of my legal right to choose or refuse medical or surgical treatment including, but not limited to, the administration of life-sustaining procedures, and I accept the consequences of such choice or refusal.
5. This advance directive shall be in effect until it is revoked.
6. I understand that I may revoke this advance directive at any time.
7. I understand and agree that if I have any prior directives, and if I sign this advance directive, my prior directives are revoked.
8. I understand the full importance of this advance directive and I am emotionally and mentally competent to make this advance directive.
9. I understand that my physician(s) shall make all decisions based upon his or her best judgment applying with ordinary care and diligence the knowledge and skill that is possessed and used by members of the physician’s profession in good standing engaged in the same field of practice at that time, measured by national standards.

Signed this \_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 2019.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CLIENT**

City of CITY

COUNTY County, Oklahoma

Date of birth: 00.00.00

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Optional for identification purposes)

This advance directive of **CLIENT** was signed in my presence.

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City City