

GENERAL ASSEMBLY OF NORTH CAROLINA  
SESSION 2015

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HOUSE BILL 146  
Committee Substitute Favorable 3/18/15

Short Title: Amend Advance Health Care Directives Laws.

(Public)

Sponsors:

Referred to:

March 4, 2015

A BILL TO BE ENTITLED

AN ACT ELIMINATING THE NEED TO HAVE ADVANCE HEALTH CARE DIRECTIVES AND HEALTH CARE POWERS OF ATTORNEY SIGNED IN THE PRESENCE OF TWO WITNESSES AND ACKNOWLEDGED BEFORE A NOTARY PUBLIC, AND INSTEAD ALLOWING FOR EXECUTION BY EITHER SIGNATURE IN THE PRESENCE OF TWO WITNESSES OR ACKNOWLEDGMENT BEFORE A NOTARY PUBLIC.

The General Assembly of North Carolina enacts:

**SECTION 1.** G.S. 32A-16(3) reads as rewritten:

"(3) Health care power of attorney. – A written instrument that substantially meets the requirements of this Article, that is signed in the presence of two qualified ~~witnesses, and~~ witnesses, or acknowledged before a notary public, pursuant to which an attorney-in-fact or agent is appointed to act for the principal in matters relating to the health care of the principal. ~~The~~ If notarized, the notary who takes the acknowledgement may but is not required to be a paid employee of the attending physician or mental health treatment provider, a paid employee of a health facility in which the principal is a patient, or a paid employee of a nursing home or any adult care home in which the principal resides."

**SECTION 2.** G.S. 32A-25.1(a) reads as rewritten:

"(a) The use of the following form in the creation of a health care power of attorney is lawful and, when used, it shall meet the requirements of and be construed in accordance with the provisions of this Article:

**HEALTH CARE POWER OF ATTORNEY**

**NOTE: YOU SHOULD USE THIS DOCUMENT TO NAME A PERSON AS YOUR HEALTH CARE AGENT IF YOU ARE COMFORTABLE GIVING THAT PERSON BROAD AND SWEEPING POWERS TO MAKE HEALTH CARE DECISIONS FOR YOU. THERE IS NO LEGAL REQUIREMENT THAT ANYONE EXECUTE A HEALTH CARE POWER OF ATTORNEY.**

*EXPLANATION: You have the right to name someone to make health care decisions for you when you cannot make or communicate those decisions. This form may be used to create a health care power of attorney, and meets the requirements of North Carolina law. However, you are not required to use this form, and North Carolina law allows the use of other forms*



1 that meet certain requirements. If you prepare your own health care power of attorney, you  
2 should be very careful to make sure it is consistent with North Carolina law.

3  
4 This document gives the person you designate as your health care agent **broad powers** to make  
5 health care decisions for you when you cannot make the decision yourself or cannot  
6 communicate your decision to other people. You should discuss your wishes concerning  
7 life-prolonging measures, mental health treatment, and other health care decisions with your  
8 health care agent. Except to the extent that you express specific limitations or restrictions in  
9 this form, your health care agent may make any health care decision you could make yourself.

10  
11 This form does not impose a duty on your health care agent to exercise granted powers, but  
12 when a power is exercised, your health care agent will be obligated to use due care to act in  
13 your best interests and in accordance with this document.

14  
15 This Health Care Power of Attorney form is intended to be valid in any jurisdiction in which it  
16 is presented, but places outside North Carolina may impose requirements that this form does  
17 not meet.

18  
19 If you want to use this form, you must complete it, sign it, and have your signature witnessed by  
20 two qualified witnesses ~~and~~ or proved by a notary public. Follow the instructions about which  
21 choices you can initial very carefully. **Do not sign this form until** two witnesses ~~and~~ or a  
22 notary public are present to watch you sign it. You then should give a copy to your health care  
23 agent and to any alternates you name. You should consider filing it with the Advance Health  
24 Care Directive Registry maintained by the North Carolina Secretary of State:  
25 <http://www.nclifelinks.org/ahcdr/>

26  
27 **1. Designation of Health Care Agent.**

28  
29 I, \_\_\_\_\_, being of sound mind, hereby appoint the following person(s) to serve  
30 as my health care agent(s) to act for me and in my name (in any way I could act in person) to  
31 make health care decisions for me as authorized in this document. My designated health care  
32 agent(s) shall serve alone, in the order named.

33  
34 A. Name: \_\_\_\_\_ Home Telephone: \_\_\_\_\_  
35 Home Address: \_\_\_\_\_ Work Telephone: \_\_\_\_\_  
36 \_\_\_\_\_ Cellular Telephone: \_\_\_\_\_

37  
38 B. Name: \_\_\_\_\_ Home Telephone: \_\_\_\_\_  
39 Home Address: \_\_\_\_\_ Work Telephone: \_\_\_\_\_  
40 \_\_\_\_\_ Cellular Telephone: \_\_\_\_\_

41  
42 C. Name: \_\_\_\_\_ Home Telephone: \_\_\_\_\_  
43 Home Address: \_\_\_\_\_ Work Telephone: \_\_\_\_\_  
44 \_\_\_\_\_ Cellular Telephone: \_\_\_\_\_

45  
46 Any successor health care agent designated shall be vested with the same power and duties as if  
47 originally named as my health care agent, and shall serve any time his or her predecessor is not  
48 reasonably available or is unwilling or unable to serve in that capacity.

49  
50 **2. Effectiveness of Appointment.**

1 My designation of a health care agent expires only when I revoke it. Absent revocation, the  
2 authority granted in this document shall become effective when and if one of the physician(s)  
3 listed below determines that I lack capacity to make or communicate decisions relating to my  
4 health care, and will continue in effect during that incapacity, or until my death, except if I  
5 authorize my health care agent to exercise my rights with respect to anatomical gifts, autopsy,  
6 or disposition of my remains, this authority will continue after my death to the extent necessary  
7 to exercise that authority.

8  
9 1. \_\_\_\_\_ (*Physician*)

10  
11 2. \_\_\_\_\_ (*Physician*)

12  
13 If I have not designated a physician, or no physician(s) named above is reasonably available,  
14 the determination that I lack capacity to make or communicate decisions relating to my health  
15 care shall be made by my attending physician.

### 16 17 **3. Revocation.**

18  
19 Any time while I am competent, I may revoke this power of attorney in a writing I sign or by  
20 communicating my intent to revoke, in any clear and consistent manner, to my health care  
21 agent or my health care provider.

### 22 23 **4. General Statement of Authority Granted.**

24  
25 Subject to any restrictions set forth in Section 5 below, I grant to my health care agent full  
26 power and authority to make and carry out all health care decisions for me. These decisions  
27 include, but are not limited to:

- 28  
29 A. Requesting, reviewing, and receiving any information, verbal or written,  
30 regarding my physical or mental health, including, but not limited to,  
31 medical and hospital records, and to consent to the disclosure of this  
32 information.
- 33  
34 B. Employing or discharging my health care providers.
- 35  
36 C. Consenting to and authorizing my admission to and discharge from a  
37 hospital, nursing or convalescent home, hospice, long-term care facility, or  
38 other health care facility.
- 39  
40 D. Consenting to and authorizing my admission to and retention in a facility for  
41 the care or treatment of mental illness.
- 42  
43 E. Consenting to and authorizing the administration of medications for mental  
44 health treatment and electroconvulsive treatment (ECT) commonly referred  
45 to as "shock treatment."
- 46  
47 F. Giving consent for, withdrawing consent for, or withholding consent for,  
48 X-ray, anesthesia, medication, surgery, and all other diagnostic and  
49 treatment procedures ordered by or under the authorization of a licensed  
50 physician, dentist, podiatrist, or other health care provider. This

1 authorization specifically includes the power to consent to measures for  
2 relief of pain.

3  
4 G. Authorizing the withholding or withdrawal of life-prolonging measures.

5  
6 H. Providing my medical information at the request of any individual acting as  
7 my attorney-in-fact under a durable power of attorney or as a Trustee or  
8 successor Trustee under any Trust Agreement of which I am a Grantor or  
9 Trustee, or at the request of any other individual whom my health care agent  
10 believes should have such information. I desire that such information be  
11 provided whenever it would expedite the prompt and proper handling of my  
12 affairs or the affairs of any person or entity for which I have some  
13 responsibility. In addition, I authorize my health care agent to take any and  
14 all legal steps necessary to ensure compliance with my instructions  
15 providing access to my protected health information. Such steps shall  
16 include resorting to any and all legal procedures in and out of courts as may  
17 be necessary to enforce my rights under the law and shall include attempting  
18 to recover attorneys' fees against anyone who does not comply with this  
19 health care power of attorney.

20  
21 I. To the extent I have not already made valid and enforceable arrangements  
22 during my lifetime that have not been revoked, exercising any right I may  
23 have to authorize an autopsy or direct the disposition of my remains.

24  
25 J. Taking any lawful actions that may be necessary to carry out these decisions,  
26 including, but not limited to: (i) signing, executing, delivering, and  
27 acknowledging any agreement, release, authorization, or other document that  
28 may be necessary, desirable, convenient, or proper in order to exercise and  
29 carry out any of these powers; (ii) granting releases of liability to medical  
30 providers or others; and (iii) incurring reasonable costs on my behalf related  
31 to exercising these powers, provided that this health care power of attorney  
32 shall not give my health care agent general authority over my property or  
33 financial affairs.

34  
35 **5. Special Provisions and Limitations.**

36  
37 (Notice: The authority granted in this document is intended to be as broad as possible so that  
38 your health care agent will have authority to make any decisions you could make to obtain or  
39 terminate any type of health care treatment or service. If you wish to limit the scope of your  
40 health care agent's powers, you may do so in this section. If none of the following are initialed,  
41 there will be no special limitations on your agent's authority.)

42  
43 A. Limitations about Artificial Nutrition or Hydration: In exercising  
44 the authority to make health care decisions on my behalf, my health  
45 care agent:

46 \_\_\_\_\_ shall NOT have the authority to withhold artificial nutrition  
47 *(Initial)* (such as through tubes) OR may exercise that authority only  
48 in accordance with the following special provisions:

49 \_\_\_\_\_  
50 \_\_\_\_\_  
51

1 \_\_\_\_\_  
2 (Initial)

shall NOT have the authority to withhold artificial hydration (such as through tubes) OR may exercise that authority only in accordance with the following special provisions:

3 \_\_\_\_\_  
4 \_\_\_\_\_  
5 \_\_\_\_\_  
6 **NOTE: If you initial either block but do not insert any special provisions, your health care agent shall have NO AUTHORITY to withhold artificial nutrition or hydration.**

7 \_\_\_\_\_  
8 (Initial)

9 B. Limitations Concerning Health Care Decisions. In exercising the authority to make health care decisions on my behalf, the authority of my health care agent is subject to the following special provisions: (Here you may include any specific provisions you deem appropriate such as: your own definition of when life-prolonging measures should be withheld or discontinued, or instructions to refuse any specific types of treatment that are inconsistent with your religious beliefs, or are unacceptable to you for any other reason.)

10 \_\_\_\_\_  
11 \_\_\_\_\_  
12 **NOTE: DO NOT initial unless you insert a limitation.**

13 \_\_\_\_\_  
14 (Initial)

15 C. Limitations Concerning Mental Health Decisions. In exercising the authority to make mental health decisions on my behalf, the authority of my health care agent is subject to the following special provisions: (Here you may include any specific provisions you deem appropriate such as: limiting the grant of authority to make only mental health treatment decisions, your own instructions regarding the administration or withholding of psychotropic medications and electroconvulsive treatment (ECT), instructions regarding your admission to and retention in a health care facility for mental health treatment, or instructions to refuse any specific types of treatment that are unacceptable to you.)

16 \_\_\_\_\_  
17 \_\_\_\_\_  
18 **NOTE: DO NOT initial unless you insert a limitation.**

19 \_\_\_\_\_  
20 (Initial)

21 D. Advance Instruction for Mental Health Treatment. (Notice: This health care power of attorney may incorporate or be combined with an advance instruction for mental health treatment, executed in accordance with Part 2 of Article 3 of Chapter 122C of the General Statutes, which you may use to state your instructions regarding mental health treatment in the event you lack capacity to make or communicate mental health treatment decisions. Because your health care agent's decisions must be consistent with any statements you have expressed in an advance instruction, you should indicate here whether you have executed an advance instruction for mental health treatment):

**NOTE: DO NOT initial unless you insert a limitation.**

\_\_\_\_\_  
(Initial) E. Autopsy and Disposition of Remains. In exercising the authority to make decisions regarding autopsy and disposition of remains on my behalf, the authority of my health care agent is subject to the following special provisions and limitations. (Here you may include any specific limitations you deem appropriate such as: limiting the grant of authority and the scope of authority, or instructions regarding burial or cremation):

**NOTE: DO NOT initial unless you insert a limitation.**

**6. Organ Donation.**

To the extent I have not already made valid and enforceable arrangements during my lifetime that have not been revoked, my health care agent may exercise any right I may have to:

\_\_\_\_\_  
(Initial) donate any needed organs or parts; or

\_\_\_\_\_  
(Initial) donate only the following organs or parts:

**NOTE: DO NOT INITIAL BOTH BLOCKS ABOVE.**

\_\_\_\_\_  
(Initial) donate my body for anatomical study if needed.

\_\_\_\_\_  
(Initial) In exercising the authority to make donations, my health care agent is subject to the following special provisions and limitations: (Here you may include any specific limitations you deem appropriate such as: limiting the grant of authority and the scope of authority, or instructions regarding gifts of the body or body parts.)

**NOTE: DO NOT initial unless you insert a limitation.**

**NOTE: NO AUTHORITY FOR ORGAN DONATION IS GRANTED IN THIS INSTRUMENT WITHOUT YOUR INITIALS.**

**7. Guardianship Provision.**

If it becomes necessary for a court to appoint a guardian of my person, I nominate the persons designated in Section 1, in the order named, to be the guardian of my person, to serve without bond or security. The guardian shall act consistently with G.S. 35A-1201(a)(5).

**8. Reliance of Third Parties on Health Care Agent.**

- 1  
2 A. No person who relies in good faith upon the authority of or any  
3 representations by my health care agent shall be liable to me, my estate, my  
4 heirs, successors, assigns, or personal representatives, for actions or  
5 omissions in reliance on that authority or those representations.  
6 B. The powers conferred on my health care agent by this document may be  
7 exercised by my health care agent alone, and my health care agent's  
8 signature or action taken under the authority granted in this document may  
9 be accepted by persons as fully authorized by me and with the same force  
10 and effect as if I were personally present, competent, and acting on my own  
11 behalf. All acts performed in good faith by my health care agent pursuant to  
12 this power of attorney are done with my consent and shall have the same  
13 validity and effect as if I were present and exercised the powers myself, and  
14 shall inure to the benefit of and bind me, my estate, my heirs, successors,  
15 assigns, and personal representatives. The authority of my health care agent  
16 pursuant to this power of attorney shall be superior to and binding upon my  
17 family, relatives, friends, and others.  
18

19 **9. Miscellaneous Provisions.**  
20

- 21 A. Revocation of Prior Powers of Attorney. I revoke any prior health care  
22 power of attorney. The preceding sentence is not intended to revoke any  
23 general powers of attorney, some of the provisions of which may relate to  
24 health care; however, this power of attorney shall take precedence over any  
25 health care provisions in any valid general power of attorney I have not  
26 revoked.  
27  
28 B. Jurisdiction, Severability, and Durability. This Health Care Power of  
29 Attorney is intended to be valid in any jurisdiction in which it is presented.  
30 The powers delegated under this power of attorney are severable, so that the  
31 invalidity of one or more powers shall not affect any others. This power of  
32 attorney shall not be affected or revoked by my incapacity or mental  
33 incompetence.  
34  
35 C. Health Care Agent Not Liable. My health care agent and my health care  
36 agent's estate, heirs, successors, and assigns are hereby released and forever  
37 discharged by me, my estate, my heirs, successors, assigns, and personal  
38 representatives from all liability and from all claims or demands of all kinds  
39 arising out of my health care agent's acts or omissions, except for my health  
40 care agent's willful misconduct or gross negligence.  
41  
42 D. No Civil or Criminal Liability. No act or omission of my health care agent,  
43 or of any other person, entity, institution, or facility acting in good faith in  
44 reliance on the authority of my health care agent pursuant to this Health Care  
45 Power of Attorney shall be considered suicide, nor the cause of my death for  
46 any civil or criminal purposes, nor shall it be considered unprofessional  
47 conduct or as lack of professional competence. Any person, entity,  
48 institution, or facility against whom criminal or civil liability is asserted  
49 because of conduct authorized by this Health Care Power of Attorney may  
50 interpose this document as a defense.  
51

E. Reimbursement. My health care agent shall be entitled to reimbursement for all reasonable expenses incurred as a result of carrying out any provision of this directive.

By signing here, I indicate that I am mentally alert and competent, fully informed as to the contents of this document, and understand the full import of this grant of powers to my health care agent.

This the \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_(SEAL)

**10. Signature.**

Signature must be witnessed by two qualified witnesses or proved by a notary public. Please complete Section A or Section B, below.

A. Witnesses

I hereby state that the principal, \_\_\_\_\_, being of sound mind, signed (or directed another to sign on the principal's behalf) the foregoing health care power of attorney in my presence, and that I am not related to the principal by blood or marriage, and I would not be entitled to any portion of the estate of the principal under any existing will or codicil of the principal or as an heir under the Intestate Succession Act, if the principal died on this date without a will. I also state that I am not the principal's attending physician, nor a licensed health care provider or mental health treatment provider who is (1) an employee of the principal's attending physician or mental health treatment provider, (2) an employee of the health facility in which the principal is a patient, or (3) an employee of a nursing home or any adult care home where the principal resides. I further state that I do not have any claim against the principal or the estate of the principal.

Date: \_\_\_\_\_ Witness: \_\_\_\_\_

Date: \_\_\_\_\_ Witness: \_\_\_\_\_

\_\_\_\_\_ COUNTY, \_\_\_\_\_ STATE

~~Sworn to (or affirmed) and subscribed before me~~Subscribed this day by  
\_\_\_\_\_  
(type/print name of signer)

\_\_\_\_\_  
(type/print name of witness)

\_\_\_\_\_  
(type/print name of witness)

B. Notarization

Sworn to (or affirmed) and subscribed before me this day by (name of principal).



1 Date: \_\_\_\_\_

2 (Official Seal)

Signature of Notary Public

3  
4 \_\_\_\_\_, Notary Public  
5 Printed or typed name

6  
7 My commission expires: \_\_\_\_\_"

8 **SECTION 3.** G.S. 90-321(c) reads as rewritten:

9 "(c) The attending physician shall follow, subject to subsections (b), (e), and (k) of this  
10 section, a declaration:

11 (1) That expresses a desire of the declarant that life-prolonging measures not be  
12 used to prolong the declarant's life if, as specified in the declaration as to any  
13 or all of the following:

- 14 a. The declarant has an incurable or irreversible condition that will  
15 result in the declarant's death within a relatively short period of time;  
16 or
- 17 b. The declarant becomes unconscious and, to a high degree of medical  
18 certainty, will never regain consciousness; or
- 19 c. The declarant suffers from advanced dementia or any other condition  
20 resulting in the substantial loss of cognitive ability and that loss, to a  
21 high degree of medical certainty, is not reversible.

22 (2) That states that the declarant is aware that the declaration authorizes a  
23 physician to withhold or discontinue the life-prolonging measures; and

24 (3) ~~That has been signed by the~~ meets either of the following requirements:

25 a. Has been signed by the declarant in the presence of two witnesses  
26 who believe the declarant to be of sound mind and who state that  
27 they (i) are not related within the third degree to the declarant or to  
28 the declarant's spouse, (ii) do not know or have a reasonable  
29 expectation that they would be entitled to any portion of the estate of  
30 the declarant upon the declarant's death under any will of the  
31 declarant or codicil thereto then existing or under the Intestate  
32 Succession Act as it then provides, (iii) are not the attending  
33 physician, licensed health care providers who are paid employees of  
34 the attending physician, paid employees of a health facility in which  
35 the declarant is a patient, or paid employees of a nursing home or any  
36 adult care home in which the declarant resides, and (iv) do not have a  
37 claim against any portion of the estate of the declarant at the time of  
38 the ~~declaration; and~~ declaration.

39 b. Has been proved before a clerk or assistant clerk of superior court, or  
40 a notary public who certifies substantially as set out in subsection  
41 (d1) of this section. A notary who takes the acknowledgement may  
42 but is not required to be a paid employee of the attending physician, a  
43 paid employee of a health facility in which the declarant is a patient,  
44 or a paid employee of a nursing home or any adult care home in  
45 which the declarant resides.

46 (4) ~~That has been proved before a clerk or assistant clerk of superior court, or a~~  
47 ~~notary public who certifies substantially as set out in subsection (d1) of this~~  
48 ~~section. A notary who takes the acknowledgement may but is not required to~~  
49 ~~be a paid employee of the attending physician, a paid employee of a health~~  
50 ~~facility in which the declarant is a patient, or a paid employee of a nursing~~  
51 ~~home or any adult care home in which the declarant resides."~~

1           **SECTION 4.** G.S. 90-321(d1) reads as rewritten:  
 2           "(d1) The following form is specifically determined to meet the requirements of  
 3 subsection (c) of this section:

4  
 5           **ADVANCE DIRECTIVE FOR A NATURAL DEATH ("LIVING WILL")**

6  
 7           **NOTE: YOU SHOULD USE THIS DOCUMENT TO GIVE YOUR HEALTH CARE**  
 8           **PROVIDERS INSTRUCTIONS TO WITHHOLD OR WITHDRAW**  
 9           **LIFE-PROLONGING MEASURES IN CERTAIN SITUATIONS. THERE IS NO**  
 10           **LEGAL REQUIREMENT THAT ANYONE EXECUTE A LIVING WILL.**

11  
 12           **GENERAL INSTRUCTIONS:** *You can use this Advance Directive ("Living Will") form to give*  
 13           *instructions for the future if you want your health care providers to withhold or withdraw*  
 14           *life-prolonging measures in certain situations. You should talk to your doctor about what these*  
 15           *terms mean. The Living Will states what choices you would have made for yourself if you were*  
 16           *able to communicate. Talk to your family members, friends, and others you trust about your*  
 17           *choices. Also, it is a good idea to talk with professionals such as your doctors, clergypersons,*  
 18           *and lawyers before you complete and sign this Living Will.*

19  
 20           *You do not have to use this form to give those instructions, but if you create your own Advance*  
 21           *Directive you need to be very careful to ensure that it is consistent with North Carolina law.*

22  
 23           *This Living Will form is intended to be valid in any jurisdiction in which it is presented, but*  
 24           *places outside North Carolina may impose requirements that this form does not meet.*

25  
 26           *If you want to use this form, you must complete it, sign it, and have your signature witnessed by*  
 27           *two qualified witnesses ~~and~~ or proved by a notary public. Follow the instructions about which*  
 28           *choices you can initial very carefully. **Do not sign this form until** two witnesses ~~and~~ or a*  
 29           *notary public are present to watch you sign it. You then should consider giving a copy to your*  
 30           *primary physician and/or a trusted relative, and should consider filing it with the Advanced*  
 31           *Health Care Directive Registry maintained by the North Carolina Secretary of State:*  
 32           *<http://www.nclifelinks.org/ahcdr/>*

33  
 34           **My Desire for a Natural Death**

35  
 36           I, \_\_\_\_\_, being of sound mind, desire that, as specified below, my life not be  
 37           prolonged by life-prolonging measures:

38  
 39           **1. When My Directives Apply**

40  
 41           My directions about prolonging my life shall apply **IF** my attending physician  
 42           determines that I lack capacity to make or communicate health care decisions and:

43  
 44           **NOTE: YOU MAY INITIAL ANY AND ALL OF THESE CHOICES.**

45  
 46           \_\_\_\_\_ I have an incurable or irreversible condition that will result  
 47           *(Initial)* in my death within a relatively short period of time.

48  
 49           \_\_\_\_\_ I become unconscious and my health care providers  
 50           *(Initial)* determine that, to a high degree of medical certainty, I will  
 51           never regain my consciousness.

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\_\_\_\_\_  
(Initial) I suffer from advanced dementia or any other condition which results in the substantial loss of my cognitive ability and my health care providers determine that, to a high degree of medical certainty, this loss is not reversible.

**2. These are My Directives about Prolonging My Life:**

In those situations I have initialed in Section 1, I direct that my health care providers:

**NOTE: INITIAL ONLY IN ONE PLACE.**

\_\_\_\_\_  
(Initial) may withhold or withdraw life-prolonging measures.

\_\_\_\_\_  
(Initial) shall withhold or withdraw life-prolonging measures.

**3. Exceptions – "Artificial Nutrition or Hydration"**

**NOTE: INITIAL ONLY IF YOU WANT TO MAKE EXCEPTIONS TO YOUR INSTRUCTIONS IN PARAGRAPH 2.**

EVEN THOUGH I do not want my life prolonged in those situations I have initialed in Section 1:

\_\_\_\_\_  
(Initial) I *DO* want to receive BOTH artificial hydration AND artificial nutrition (for example, through tubes) in those situations.

**NOTE: DO NOT INITIAL THIS BLOCK IF ONE OF THE BLOCKS BELOW IS INITIALED.**

\_\_\_\_\_  
(Initial) I *DO* want to receive ONLY artificial hydration (for example, through tubes) in those situations.

**NOTE: DO NOT INITIAL THE BLOCK ABOVE OR BELOW IF THIS BLOCK IS INITIALED.**

\_\_\_\_\_  
(Initial) I *DO* want to receive ONLY artificial nutrition (for example, through tubes) in those situations.

**NOTE: DO NOT INITIAL EITHER OF THE TWO BLOCKS ABOVE IF THIS BLOCK IS INITIALED.**

**4. I Wish to be Made as Comfortable as Possible**

I direct that my health care providers take reasonable steps to keep me as clean, comfortable, and free of pain as possible so that my dignity is maintained, even though this care may hasten my death.

**5. I Understand my Advance Directive**

I am aware and understand that this document directs certain life-prolonging measures to be withheld or discontinued in accordance with my advance instructions.

**6. If I have an Available Health Care Agent**

If I have appointed a health care agent by executing a health care power of attorney or similar instrument, and that health care agent is acting and available and gives instructions that differ from this Advance Directive, then I direct that:

\_\_\_\_\_ Follow Advance Directive: This Advance Directive will  
(Initial) **override** instructions my health care agent gives about  
prolonging my life.

\_\_\_\_\_ Follow Health Care Agent: My health care agent has  
(Initial) authority to **override** this Advance Directive.

**NOTE: DO NOT INITIAL BOTH BLOCKS. IF YOU DO NOT INITIAL EITHER BOX, THEN YOUR HEALTH CARE PROVIDERS WILL FOLLOW THIS ADVANCE DIRECTIVE AND IGNORE THE INSTRUCTIONS OF YOUR HEALTH CARE AGENT ABOUT PROLONGING YOUR LIFE.**

**7. My Health Care Providers May Rely on this Directive**

My health care providers shall not be liable to me or to my family, my estate, my heirs, or my personal representative for following the instructions I give in this instrument. Following my directions shall not be considered suicide, or the cause of my death, or malpractice or unprofessional conduct. If I have revoked this instrument but my health care providers do not know that I have done so, and they follow the instructions in this instrument in good faith, they shall be entitled to the same protections to which they would have been entitled if the instrument had not been revoked.

**8. I Want this Directive to be Effective Anywhere**

I intend that this Advance Directive be followed by any health care provider in any place.

**9. I have the Right to Revoke this Advance Directive**

I understand that at any time I may revoke this Advance Directive in a writing I sign or by communicating in any clear and consistent manner my intent to revoke it to my attending physician. I understand that if I revoke this instrument I should try to destroy all copies of it.

This the \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

\_\_\_\_\_  
Print Name \_\_\_\_\_

**10. Signature.**

Signature must be witnessed by two qualified witnesses or proved by a notary public. Please complete Section A or Section B, below.

A. Witnesses

I hereby state that the declarant, \_\_\_\_\_, being of sound mind, signed (or directed another to sign on declarant's behalf) the foregoing Advance Directive for a Natural Death in my presence, and that I am not related to the declarant by blood or marriage, and I would not be entitled to any portion of the estate of the declarant under any existing will or codicil of the declarant or as an heir under the Intestate Succession Act, if the declarant died on this date without a will. I also state that I am not the declarant's attending physician, nor a licensed health care provider who is (1) an employee of the declarant's attending physician, (2) nor an employee of the health facility in which the declarant is a patient, or (3) an employee of a nursing home or any adult care home where the declarant resides. I further state that I do not have any claim against the declarant or the estate of the declarant.

Date: \_\_\_\_\_ Witness: \_\_\_\_\_

Date: \_\_\_\_\_ Witness: \_\_\_\_\_

\_\_\_\_\_ COUNTY, \_\_\_\_\_ STATE

~~Sworn to (or affirmed) and subscribed before me~~ Subscribed this day by

\_\_\_\_\_ (type/print name of declarant)

\_\_\_\_\_ (type/print name of witness)

\_\_\_\_\_ (type/print name of witness)

B. Notarization

Sworn to (or affirmed) and subscribed before me this day by (name of principal).

Date \_\_\_\_\_ (Official Seal) \_\_\_\_\_ Signature of Notary Public

\_\_\_\_\_, Notary Public Printed or typed name

My commission expires: \_\_\_\_\_"

SECTION 5. This act becomes effective October 1, 2015, and applies to directives executed on or after that date.