Saint Alphonsus

Idaho Living Will and Durable Power of Attorney for Health Care

for

Name: _____ **Date of Birth:** _____

Living Will

A Directive to Withhold or to Provide Treatment

I willfully and voluntarily make known my desires related to medical care at the end of life, specifically the option of artificially prolonging my life under the circumstances listed below. This Directive is only effective if I am unable to communicate my instructions and:

a.) I have an incurable or irreversible injury, disease, illness or condition and one (1) medical doctor has examined me and certified that:

1. My injury, disease, illness or condition is terminal; **and**
2. The application of artificial life-sustaining procedures would serve only to prolong artificially my life; **and**
3. My death is imminent, whether or not artificial life-sustaining procedures are utilized; **or**

b.) I have been diagnosed as being in a persistent vegetative state.

In such event, I direct that the following marked expression of my intent be followed and that I receive any medical treatment or care that may be required to keep me free of pain or distress.

Check the box for only one of the following three options and initial line after the box

Option 1:

☐ _____ **All Treatment, Artificial Nutrition and Hydration**: I direct that all medical treatment, care and procedures necessary to sustain my life be provided to me. Nutrition and hydration, whether artificial or non-artificial, shall not be withheld or withdrawn from me if I would likely die primarily from malnutrition or dehydration rather than from my injury, disease, illness or condition.

OR **Option 2**:

☐ _____ **Nutrition and/or Hydration**: I direct that all medical treatment, care and procedures, including artificial life-sustaining procedures, be withheld or withdrawn, ***EXCEPT*** that both artificial nutrition and artificial hydration, shall be administered. If you prefer to only receive one form and not the other, check one box below and initial the line after box. (If none of the following boxes is checked and initialed, then both artificial nutrition and artificial hydration shall be administered):

A. ☐ _____ ***Only artificial hydration*** of any nature, shall be administered;

B. ☐ _____ ***Only artificial nutrition,*** of any nature, shall be administered.

OR **Option 3**:

☐ _____ **Comfort Care**: I direct that all medical treatment, care, and procedures be withheld or withdrawn, including withholding or withdrawing the administration of artificial nutrition and hydration. I direct nutrition and hydration be offered for as long as I desire and am able to take liquids, ice chips and/or food by mouth. I direct medical treatment or care that may be required to keep me free of pain or distress be provided.

- This Directive shall be the final expression of my legal right to refuse or accept medical and surgical treatment, and I accept the consequences of such refusal or acceptance.
- If I have been diagnosed as pregnant, this Directive shall have no force during the course of my pregnancy.
- I understand the full importance of this Directive and am mentally competent to make this Directive.
- No participant in the making of this Directive or in its being carried into effect shall be held responsible in any way for complying with my directions.

Check statements below:

I have _____ have not _____ discussed these decisions with my physician.

I have _____ have not _____ completed a **Physician Orders for Scope of Treatment (POST)** form.

If and when a POST form is signed by my physician, this living will shall be deemed modified to be compatible with the terms of the POST form.

DURABLE POWER OF ATTORNEY FOR HEALTH CARE
(HEALTH CARE AGENT)

1. **CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE**. By this portion of this Directive, I intend to create a durable power of attorney for health care (also known as health care agent). This power of attorney shall not be affected by my subsequent incapacity. This power shall be effective only when I am unable to communicate rationally.

2. DESIGNATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE (HEALTH CARE AGENT). *None of the following may be designated as your agent: 1) your treating health care provider; 2) a nonrelative employee of your treating health care provider; 3) an operator of a community care facility; or 4) a nonrelative employee of an operator of a community care facility. If the agent or an alternate agent designated in this Directive is your spouse, and your marriage is dissolved, the designation shall be thereupon revoked.*

I do hereby designate and appoint the following individual as my attorney in fact (agent) to make health care decisions for me as authorized in this Directive. *For the purposes of this Directive, "health care decision" means consent, refusal of consent, or withdrawal of consent to any care, treatment, service or procedure to maintain, diagnose or treat an individual's physical condition* (Insert name, address, and telephone number of <u>one</u> individual only as your agent to make health care decisions for you.)

Health Care Agent

Name: _____

Address: _____

Telephone Number: _____

3. DESIGNATION OF ALTERNATE AGENTS. *You may designate alternate agents, but are not required to do so. Any alternate agent you designate will be able to make the same health care decisions as the agent you designated in paragraph two (2) above, in the event that agent is unable or ineligible to act as your agent. If an alternate agent you designated is your spouse, he or she becomes ineligible to act as your agent if your marriage thereafter is dissolved.*

If the person designated as my agent in paragraph two (2) is not available or becomes ineligible to act as my agent to make a health care decision for me or loses the mental capacity to make health care decisions for me, or if I revoke that person's appointment or authority to act as my agent to make health care decisions for me, then I designate and appoint the following persons to serve as my agent to make health care decisions for me as authorized in this Directive. Such persons shall serve in the order listed below.

A. First Alternate Health Care Agent

Name: _____

Address: _____

Telephone Number: _____

B. Second Alternate Health Care Agent

Name: _____

Address: _____

Telephone Number: _____

C. Third Alternate Health Care Agent

Name: _____

Address: _____

Telephone Number: _____

4. GENERAL STATEMENT OF AUTHORITY GRANTED. I hereby grant to my agent full power and authority to make health care decisions for me to the same extent that I could make such decisions for myself if I had the capacity to do so. In exercising this authority, my agent shall make health care decisions that are consistent with my desires as stated in the Directive or otherwise made known to my agent, including, but not limited to, my desires concerning obtaining or refusing or withdrawing artificial life-sustaining care, treatment, services, and procedures, including such desires set forth in a living will, POST or similar document executed by me, if any.

If you wish to limit the authority of your agent to make health care decisions for you, you can state the limitations in paragraph five (5), Statement of Desires, Special Provisions, and Limitations.

5. STATEMENT OF DESIRES, SPECIAL PROVISIONS AND LIMITATIONS. *Your agent must make health care decisions that are consistent with your known desires. You can, but are not required to, state your desires in the space provided below. You should consider whether you want to include a statement of your desires concerning:*

- *Artificial life-sustaining care, treatment, services, and procedures, and*
- *Other matters relating to your health care, including a list of one or more persons whom you designate to be able to receive medical information about you and/or to be allowed to visit you in a medical institution.*
- *You can also make your desires known to your agent by discussing your desires with your health care agent or by some other means.*
- *If there are any types of treatment that you do not want to be used, you should state them in the space below. If you want to limit in any other way the authority given your agent by this Directive, you should state the limits in the space below.*
- *If you do not state any limits, your agent will have broad powers to make health care decisions for you, except to the extent that there are limits provided by law.*

Continued

In exercising the authority under this durable power of attorney for health care, my agent shall act consistently with my desires as stated below and is subject to the special provisions and limitations as stated in a living will or similar document executed by me, if any. Additional statement of desires, special provisions, and limitations: _____

_____

_____

_____

_____

6. INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY PHYSICAL OR MENTAL HEALTH.

A. General Grant of Power and Authority. Subject to any limitations in this Directive, my agent has the power and authority to do all of the following: 1) Request, review, and receive any information, verbal or written, regarding my physical or mental health including, but not limited to medical and hospital records; 2) complete on my behalf any releases or other documents that may be required in order to obtain this information; 3) Consent to the disclosure of this information; and 4) Consent to the donation of any of my organs for medical purposes. *If you want to limit the authority of your agent to receive and disclose information relating to your health, you must state the limitations in paragraph five (5) above.*

B. HIPAA Release Authority. My agent shall be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I authorize any physician, health care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy, or other covered health care provider, any insurance company, and the Medical Information Bureau, Inc. or other health care clearinghouse that has provided treatment or services to me, or that has paid for or is seeking payment from me for such services, to give, disclose, and release to my agent, without restriction, all of my individually identifiable health information and medical records regarding any past, present, or future medical or mental health condition, including all information relating to the diagnosis of HIV/AIDS, sexually transmitted diseases, mental illness, and drug or alcohol abuse. The authority given my agent shall supersede any other agreement that I may have made with my health care providers to restrict access to or disclosure of my individually identifiable health information. The authority given my agent has no expiration date and shall expire only in the event that I revoke the authority in writing and deliver it to my health care provider.

7. SIGNING DOCUMENTS, WAIVERS, AND RELEASES. Where necessary to implement the health care decisions that my agent is authorized by this Directive to make, my agent has the power and authority to execute on my behalf all of the following: a) Documents titled, or purporting to be a "Refusal to Permit Treatment" and/or a "Leaving Hospital Against Medical Advice"; and b) any necessary waiver or release from liability required by a hospital or physician.

8. PRIOR DESIGNATIONS REVOKED I revoke any prior durable power of attorney for health care. It is my desire that this document, duly executed in Idaho, shall be presumed to comply with the provisions of any similar Act in any other State, and may, in good faith, be relied upon by a health care provider or health care facility in Idaho as well as any other state.

I sign my name to this Statutory Form Living Will and Durable Power of Attorney for Health Care on the date set forth below in (City)_____ (State)_____.

_____ _____

SIGNATURE **DATE**