Advance Healthcare Directive

For _____ date of birth _____

Signed on _____, 20___

I, _____, of _____ County, Pennsylvania, make this Advance Healthcare Directive of my own free will. I ask that my family, loved ones and caregivers honor my wishes which are intended to lessen any burden placed on them and minimize any feelings of guilt.

My Healthcare Choices

If I ever lose my ability to communicate my wishes, my healthcare agent shall make decisions consistent with my stated desires and values and is subject to any special instructions or limitations that I may list here. I want my healthcare agent to make decisions that, in his or her best judgment, would best achieve the acceptable quality of life I have outlined below.

To me an acceptable quality of life is when I can:

If I reach a point where doctors are reasonably certain that I will never regain an acceptable quality of life as outlined above, I want to stop or withdraw all care and treatment that would only prolong my life; I want to receive care and treatment that will make me comfortable. The following are important to me for comfort: *(If you don't write specific wishes, your physician and nurses will provide the best standard of care possible.)*

Print name: _____

Please initial the following if you agree:

____ I consent to donate any organs or tissue if I am a candidate.

Other Instructions I want my healthcare agent to follow based on my moral, religious or ethical considerations:

My Healthcare Agent

I elect to name a healthcare agent if I am no longer able to make my own healthcare decisions

Name of agent: _____ Relationship: _____

If my agent is unable to serve for any reason then my choice for healthcare agent is:

First alternate agent: _____ Relationship: _____

If my alternate agent is unable to serve for any reason then my choice for healthcare agent is:

Second alternate agent: _____ Relationship: _____

For current contact information, see attached page.

Please note:

____ My healthcare agent must follow my healthcare choices

or

____ My healthcare choices are only guidance. My healthcare agent shall have final say and may override any of my choices.

 Print name: _____

Healthcare Agent's Powers

- I want my healthcare agent to be able to do the following:
- To authorize, withhold, or withdraw medical care and surgical procedures,including a DNR order.
- To authorize, withhold, or withdraw nutrition (food) or hydration (water) medically supplied by tube through my nose, stomach, intestines, arteries, or veins.
- To authorize my admission to or discharge from a medical, nursing, residential, or similar facility and to make agreements for my care and health insurance for my care, including hospice and/or palliative care.

Effective immediately, I authorize all healthcare providers and insurers to disclose to my healthcare agent (personal representative), upon my healthcare agent's request, any information, including medical records, regarding my physical or mental health which may be private and protected by law.

Having carefully read this document, I have signed it on this _____ day of _____, 20___, revoking all previous healthcare directives, healthcare powers of attorney, living wills, and medical healthcare treatment instructions.

_____
Signature (Principal)

_____ _____
Witness Address

_____ _____
Witness Address

Notarization (optional)

On this _____ day of _____, 20___, before me personally appeared the aforesaid declarant and principal, to me known to be the person described in and who executed the foregoing instrument and acknowledged that he/she executed the same as his/her free act and deed.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal in the County of Bucks, State of Pennsylvania, the day and year first above written.

_____
Notary

 Print name: _____

Current Healthcare Agent Contact Information

For _____ as of _____, 20___

Healthcare agent appointed in my Advance Directive:

Name: _____ Relationship: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Email: _____

First alternative Healthcare agent appointed in my Advance Directive:

Name: _____ Relationship: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Second alternative Healthcare agent appointed in my Advance Directive:

Name: _____ Relationship: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Print name: _____