

# CALIFORNIA POWER OF ATTORNEY FOR HEALTH CARE AND HEALTH CARE INSTRUCTION FORM

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

- WITH THIS FORM YOU MAY DO ANY OR ALL OF THE FOLLOWING:
  1. NAME AN AGENT TO MAKE HEALTH CARE DECISIONS FOR YOU IF YOU CANNOT.
  2. INSTRUCT DOCTORS AND OTHER HEALTH CARE PROFESSIONALS HOW YOU WOULD LIKE TO BE TREATED IF YOU ARE HURT OR SERIOUSLY ILL AND UNABLE TO TELL THEM YOUR WISHES.
- READ THE FORM CAREFULLY. CROSS OUT ANY PROVISION YOU DO NOT WANT.
- THIS FORM REVOKES ANY PRIOR DIRECTIVES YOU HAVE MADE.
- AFTER YOU COMPLETE THIS FORM SIGN AND DATE IT. TWO WITNESSES OR A NOTARY MUST ALSO SIGN AND DATE IT.

My name is: \_\_\_\_\_.

In this document I appoint an agent. That agent will make health care decisions for me in the future, if and when I no longer have the mental capacity to make my own health care decisions. My primary care physician will determine when I am unable to make health care decisions for myself.

## Part 1 - NAMING YOUR AGENT (If you do not have an agent, please proceed to Part 2 on page 3.)

*The following persons **cannot** be selected as your agent or alternate agent:*

- Your primary physician.
- An employee of the health care institution or residential care facility where you receive care (unless you are related to that person).

### AGENT

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
City State Zip

Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

### 1<sup>ST</sup> ALTERNATE AGENT (If Agent is unavailable or unwilling to serve.)

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
City State Zip

Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

**2<sup>ND</sup> ALTERNATE AGENT (If Agent and 1<sup>ST</sup> Alternate Agent are unavailable or unwilling to serve.)**

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
City State Zip

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.

Also, except as limited by this document, this authority includes the authority to authorize an autopsy, donate all or part of my body, and/or determine the disposition of my remains. The agent's actions must be consistent with my will or trust, and with any funeral arrangements or other arrangements which I have made. (Cross this out if you do not wish your agent to have this authority.)

**AGENT'S AUTHORITY UNDER HIPAA & CMIA**

My agent shall be my personal representative under HIPAA and CMIA and shall have the same rights to inspect, obtain and disclose my protected health information as I have.

**I make the following instructions to my agent:**

I do not want efforts made to prolong my life and I do not want life-sustaining treatment to be provided or continued: (1) if I am in an irreversible coma or persistent vegetative state; or (2) if I am terminally ill and the use of life-sustaining procedures would serve only to artificially delay the moment of my death; or (3) under any other circumstances where the burdens of treatment outweigh the expected benefits. In making decisions about life sustaining treatment under (3) above, I want my agent to consider the relief of suffering and the quality of my life as well as the extent of the possible prolongation of my life.

**If this statement reflects your desires, initial here:** \_\_\_\_\_

**Other health care instruction to my agent:** \_\_\_\_\_

**NOMINATION OF CONSERVATOR:** If a conservator of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able or reasonably available to act as conservator, I nominate the alternate agents whom I have named, in the order designated. (Cross out if not desired.)

**AGENT'S OBLIGATIONS**

1. My agent shall make decisions for me in accordance with this power of attorney, other instructions I make in this form and my personal wishes, to the extent my agent knows them. If my wishes on a subject are not known, the agent shall make decisions consistent with my best interest, taking into account my personal values to the extent they are known to my agent.
2. My agent shall provide a copy of this advance health care directive to any health care provider or facility that takes on responsibility for my care.

**Part 2 - HEALTH CARE INSTRUCTIONS (For individuals without an agent or for when no agent is available.)**

If I am in an irreversible coma or persistent vegetative state; or if I am terminally ill and the provision of life sustaining procedures would serve to artificially delay the moment of my death; then, I make the following instruction, by placing my signature in front of my request:

\_\_\_\_\_ I authorize all treatments to prolong my life for as long as possible.

\_\_\_\_\_ I authorize the treatment needed to provide me with food, water, and pain control, and to keep me comfortable, but otherwise do not authorize active treatment for my medical conditions.

\_\_\_\_\_ I authorize the treatment needed to provide me with pain control and to keep me comfortable, but do not authorize the provision of food or water through a tube or an intravenous line, and do not authorize active treatment for my medical conditions.

**Other health care instructions:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**REVOCAION 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** (Sign and date form here in front of witnesses or a notary.)

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.)*

**STATEMENT OF WITNESSES**

*This document must either be notarized, or signed by two witnesses. If the principal (the person appointing the agent) currently resides in a nursing facility, this document also must be witnessed by a representative of California's Long-Term Care Ombudsman Program. If the two-witness method is chosen, the Ombudsman Program representative may serve as one of the two witnesses, or may serve as a third witness. If the notarization method is chosen, the Ombudsman Program representative 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: \_\_\_\_\_  
*City* *State* *Zip*

**Second Witness:** \_\_\_\_\_  
*Name (printed)* *Signature*

Date: \_\_\_\_\_ Address: \_\_\_\_\_  
*City* *State* *Zip*

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: \_\_\_\_\_

**DECLARATION OF OMBUDSMAN PROGRAM REPRESENTATIVE**

(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 an ombudsman designated by the California Department of Aging and that I am serving as a witness as required by Section 4675 of the California Probate Code.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

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

State of California, County of \_\_\_\_\_  
 On this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_, before me, the undersigned, a Notary Public in and for said State, personally appeared \_\_\_\_\_, personally known to me or 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 it in his/her authorized capacity and that by his/her signature on the instrument he/she executed the instrument.

WITNESS my hand and official seal.

Signature \_\_\_\_\_

**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.**