

## Health Care Directives

**Purpose of Form**

Part I. Allows you to appoint another person (called an agent) to make health care decisions if a doctor decides you are unable to do so.  
Part II. Allows you to give written instructions about what you want.  
Part III. Requires you and others to sign and date to make this legal.

**My personal information**

My name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Home phone: (    ) \_\_\_\_\_  
Work phone: (    ) \_\_\_\_\_  
Date of birth: \_\_\_\_\_  
Social Security # \_\_\_\_\_

- I revoke all living wills, Durable Powers of Attorney for Health Care, or other written advanced health care directives I have signed in the past.

### Part I: Naming an Agent

**Agent Duties**

My health care agent can:  
\* Make health care decisions for me if I am unable to make and communicate decisions for myself.  
\* Make decisions based on any instructions in Part II of this document or in other documents.  
\* Make decisions based on what he or she knows about my wishes.  
\* Act in my best interests if specific instructions are not available.

**(If needed) Reason for naming health care provider**

I have named as my agent a health care provider, or employee of a health care provider, who is currently or might be providing direct care to me when decisions are needed. That person is not related to me by blood, marriage, registered domestic partnership, or adoption. My reasons for wanting to appoint that person as my agent are: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**My primary health care agent**

I appoint:  
Agent's name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Home phone: (    ) \_\_\_\_\_    Work phone: (    ) \_\_\_\_\_  
Cell phone: (    ) \_\_\_\_\_

**My first  
alternate  
health care  
agent**

Agent's name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Home phone: ( ) \_\_\_\_\_ Work phone: ( ) \_\_\_\_\_  
Cell phone: ( ) \_\_\_\_\_

**My second  
alternate  
health care  
agent**

Agent's name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Home phone: ( ) \_\_\_\_\_ Work phone: ( ) \_\_\_\_\_  
Cell phone: ( ) \_\_\_\_\_

**My third  
alternate  
health care  
agent**

Agent's name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Home phone: ( ) \_\_\_\_\_ Work phone: ( ) \_\_\_\_\_  
Cell phone: ( ) \_\_\_\_\_

**Powers of  
my agent**

If I am unable to decide or communicate for myself, my agent has the power to:

- \* Consent to, refuse, or withdraw any health care, treatment, service or procedure
- \* Stop or not start health care which is keeping or might be keeping me alive
- \* Choose my health care providers
- \* Choose where I live when I need health care and what personal security measures are needed to keep me safe
- \* *Authority under HIPAA:* I intend for my Agent herein appointed to 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. I grant to my Agent the power and authority to serve as my Personal Representative for all purposes under the Health Insurance Portability and Accountability Act of 1996 and its regulations ("HIPAA"), 42 USC 1320d and 45 CFR 160-164.

**Limiting the  
powers of  
my agent**

I wish to limit the powers of my health care agent in the following ways:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Additional powers of my agent**

If I want my agent to have any of the following powers, I must initial the line in front of the statement.

I also authorize my agent to:

\_\_\_\_\_ Make health care decisions for me even if I am able to decide or communicate for myself.

\_\_\_\_\_ Carry out my wishes regarding a funeral, burial, or what will happen to my body when I die.

\_\_\_\_\_ Make decisions about mental health treatment including electroconvulsive therapy and antipsychotic medication, including neuroleptics.

\_\_\_\_\_ In the event I am pregnant, determine whether to attempt to continue my pregnancy to delivery based upon my agent's understanding of my values, preferences, or instructions.

\_\_\_\_\_ Continue as my health care agent even if a dissolution, annulment, or termination of our marriage or domestic partnership is in process or has been completed.

**Part II: Health Care Instructions**

I am attaching additional instructions concerning my health care values and preferences to My Health Care Directives. *Initial one line:* \_\_\_\_\_ Yes \_\_\_\_\_ No

I authorize donation of my organs, tissues, or other body parts after my death.  
*Initial one line:* \_\_\_\_\_ Yes \_\_\_\_\_ No

I give the following instructions about my health care (my values and beliefs, what I do and do not want, views about medical treatments and situations). \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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### Part III: Making This Document Legal

**My  
Signature/  
mark and  
date**

I agree with everything in this document and have made this document willingly:

My signature: \_\_\_\_\_  
Date: \_\_\_\_\_  
(month / day / year)

### Either Notary Public or Witnesses

**Notary  
Public**

STATE OF MINNESOTA  
COUNTY OF \_\_\_\_\_

NOTE: Must not be named as agent or alternate agent.

This document was signed or acknowledged before me this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_ by the above named principal.  
(month) (year)

\_\_\_\_\_  
Signature of Notary Public

**Two  
Witnesses**

Note: Only one witness can be a direct care provider or employee of a provider on the day this is signed.

This document was signed or acknowledge in my presence. I am not an agent or alternate agent in this document.

Witness Signature: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Date: \_\_\_\_\_  
(month / day / year)

Witness Signature: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Date: \_\_\_\_\_  
(month / day / year)

Paraphrased from Marlene Stum 04/05  
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