RUTHERFORD REGIONAL
HEALTH SYSTEM

Your Rights as a Patient

Legal Documents
To Assure
Future Health Care Choices

ADVANCE DIRECTIVES

YOUR RIGHT TO MAKE HEALTH CARE DECISIONS UNDER THE LAW IN NORTH CAROLINA

INTRODUCTION

North Carolina and federal law give every competent adult, 18 years or older, the right to make their own health care decisions, including the right to decide what medical care or treatment to accept, reject or discontinue. If you do not want to receive certain types of treatment or you wish to name someone to make health care decisions for you, you have the right to make these desires known to your doctor, hospital or other health care providers, and in general, have these rights respected. You also have the right to be told about the nature of your illness in terms that you can understand, the general nature of the proposed treatments, the risks of failing to undergo these treatments and any alternative treatments or procedures that may be available to you.

However, there may be times when you cannot make your wishes known to your doctor or other health care providers. For example, if you were taken to a hospital in a coma, would you want the hospital's medical staff to know what your specific wishes are about the medical care that you want or do not want to receive.

This booklet describes what North Carolina and federal law have to say about your right to inform your health care providers about medical care and treatment you want, or do not want, and about your right to select another person to make these decisions for you, if you are physically or mentally unable to make them yourself.

To make these very difficult issues easier to understand, we have presented the information in the form of questions and answers. Because this is an important matter, we urge you to talk to your spouse, family, close friends, personal advisor, your doctor and your attorney before deciding whether or not you want an advance directive.

QUESTIONS AND ANSWERS

GENERAL INFORMATION ABOUT ADVANCE DIRECTIVES

What are "Advance Directives"?

Advance directives are documents which state your choices about medical treatment or name someone to make decisions about your medical treatment, if you are unable to make these decisions or choices yourself. They are called "advance" directives because they are signed in advance to let your doctor and other health care providers know your wishes concerning medical treatment. Through advance directives, you can make legally valid decisions about your future medical care.

North Carolina law recognizes 3 types of advance directives:

1) A Declaration (Living Will).
2) A Health Care Power of Attorney.
3) An Advance Instruction for Mental Health Treatment.

Do I have to have an Advance Directive?

No. It is entirely up to you whether you want to prepare any documents. But if questions arise about the kind of medical treatment that you want or do not want, advance directives may help to solve these important issues. Your doctor or any health care provider cannot require you to have an advance directive in order to receive care; nor can they prohibit you from having an advance directive. Moreover, under North Carolina law, no health care provider or insurer can charge a different fee or rate depending on whether or not you have executed an advance directive.

What will happen if I do not make an Advance Directive?

If you cannot speak for yourself and have not made an advance directive, your doctor or other health care providers will generally look to your family or friends for decisions about your care. But if your doctor or your health care facility is unsure or if your family members cannot agree, they may have to ask the court to appoint a person (called a guardian) to make those decisions for you.

How do I know what treatment I want?

Your doctor must inform you about your medical condition and what different treatments can do for you. Many treatments have serious side effects. Your doctor must give you information, in language that you can understand, about serious problems that medical treatment is likely to cause. Often, more than one treatment might help you and different people might have different ideas on which is best. Your doctor can tell you the treatments that are available to you, but he cannot choose for you. That choice depends on what is important to you.

Whom should I talk to about Advance Directives?

Before writing down your instructions, you should talk to those people closest to you and who are concerned about your care and feelings. Discuss them with your family, your doctor, friends and other appropriate people, such as a member of your clergy or your lawyer. These are the people who will be involved with your health care if you are unable to make your own decisions.

When do Advance Directives go into effect?

It is important to remember that these directives only take effect when you can no longer make your own health care decisions. As long as you are able to give "informed consent," your health care providers will rely on **YOU** and **NOT** on your advance directives.

What is "Informed Consent"?

Informed consent means that you are able to understand the nature, extent and

probable consequences of proposed medical treatments and you are able to make rational evaluations of the risks and benefits of those treatments as compared with the risks and benefits of alternate procedures **AND** you are able to communicate that understanding in any way.

How will health care providers know if I have any Advance Directives?

All hospitals, nursing homes, home health agencies, HMOs and all other health care facilities that accept federal funds must ask if you have an advance directive, and if so, they must see that it is made part of your medical records.

Will my Advance Directives be followed?

Generally, yes, if they comply with North Carolina law. Federal law requires your health care providers to give you their written policies concerning advance directives. A summary statement of those policies is provided for you at the back of this book. It may happen that your doctor or other health care provider cannot or will not follow your advance directives for moral, religious or professional reasons, even though they comply with North Carolina law. If this happens, they must immediately tell you. Then they must also help you transfer to another doctor or facility that will do what you want.

Can I change my mind after I write an Advance Directive?

Yes. At any time, you can cancel or change any advance directive that you have written. To cancel your directive, simply destroy the original document and tell your family, friends, doctor and anyone else who has copies that you have cancelled them. To change your advance directives, simply write and date a new one. Again, give copies of your documents to all the appropriate parties, including your doctor.

Do I need a lawyer to help me make an Advance Directive?

A lawyer may be helpful and you might choose to discuss these matters with him or her, but there is no legal requirement in North Carolina to do so. You may use the forms that are provided in this booklet to execute your advance directives.

Will my North Carolina Advance Directive be valid in another state?

The laws on advance directives differ from state to state, so it is unclear whether a North Carolina advance directive will be valid in another state. Because an advance directive is a clear expression of your wishes about medical care, it will influence that care no matter where you are admitted. However, if you plan to spend a great deal of time in another state, you might want to consider executing an advance directive that meets all the legal requirements of that state.

Will Advance Directives from other states be valid in North Carolina?

An advance directive executed in another state may not meet all the requirements of North Carolina law. To make sure you have a legal advance directive, you should execute North Carolina forms or have your attorney review the advance directive from the other state.

What should I do with my Advance Directives?

You should keep them in a safe place where your family members can get to them. Do **NOT** keep the original copies in your safe deposit box. Give copies of these documents to as many of the following people as you are comfortable with: your spouse and other family members; your doctor; your lawyer; your clergyperson; and any local hospital or nursing home where you may be residing. Another idea is to keep a small wallet card in your purse or wallet which states that you have an advance directive and who should be contacted. Wallet cards are provided for you at the back of this booklet for that purpose. You may also register your advance directives with the Secretary of State's Office in Raleigh. Call 919-807-2000 for more information.

DECLARATION (LIVING WILL)

What is a "Living Will"?

A living will is a document which tells your doctor or other health care providers whether or not you want life-sustaining treatments or procedures administered to you if you are in a terminal and incurable condition or a persistent vegetative state. It is called a "living will" because it takes effect while you are still living.

Is a "Living Will" the same as a "Will" or "Living Trust"?

No. Wills and living trusts are financial documents which allow you to plan for the distribution of your financial assets and property after your death. A living will only deals with medical issues while you are still living. Wills and living trusts are complex legal documents and you usually need legal advice to execute them. You do not need a lawyer to complete your North Carolina living will.

When does a North Carolina Living Will go into effect?

A North Carolina living will goes into effect when: 1) your doctor has a copy of it, and 2) your doctor has decided that you are no longer able to make your own health care decisions, and 3) your doctor and another doctor have determined that you are in a terminal and incurable condition or a persistent vegetative state.

What are "life-sustaining" treatments?

These are treatments or procedures that are not expected to cure your terminal condition or make you better. They only prolong dying. Examples are mechanical respirators which help you breathe, kidney dialysis which clears your body of wastes and cardiopulmonary resuscitation (CPR) which restores your heartbeat.

What is a "terminal and incurable" condition?

A terminal and incurable condition is defined as a condition for which the administration of medical treatment will only prolong the dying process and without administration of these treatments or procedures, death will occur in a relatively short period of time.

What is a "persistent vegetative state"?

A persistent vegetative state means that a patient is in a permanent coma or state of unconsciousness caused by illness, injury or disease. The patient is totally unaware of himself or herself, his or her surroundings and environment and to a reasonable degree of medical certainty, there can be no recovery.

Is a Living Will the same as a "Do Not Resuscitate (DNR)" order?

No. A North Carolina living will covers almost all types of life-sustaining treatments and procedures. A "Do Not Resuscitate" order covers two types of life-threatening situations. A DNR order is a document prepared by your doctor at your direction and placed in your medical records. It states that if you suffer cardiac arrest (your heart stops beating) or respiratory arrest (you stop breathing), your health care providers are not to try to revive you by any means.

Will I receive medication for pain?

Unless you state otherwise in the living will, medication for pain will be provided where appropriate to make you comfortable and will not be discontinued.

Can my doctor be sued or prosecuted for carrying out the provisions of a North Carolina Living Will?

No. The North Carolina Right to a Natural Death Act specifically states that the withholding or discontinuance of any extraordinary means of keeping a patient alive, or the withholding or discontinuance of artificial nutrition and hydration shall not be considered the cause of death for any civil or criminal purpose, nor shall it be considered unprofessional conduct.

Does a North Carolina Living Will affect insurance?

No. The making of a living will, in accordance with North Carolina law, will not affect the sale or issuance of any life insurance policy, nor shall it invalidate or change the terms of any insurance policy. In addition, the removal of life-support systems according to North Carolina law, shall not, for any purpose, constitute suicide, homicide or euthanasia, nor shall it be deemed the cause of death for the purposes of insurance coverage.

Does a North Carolina Living Will have to be signed and witnessed?

Yes. You must sign (or have someone sign the document in your presence and at your direction, if you are unable to sign) and date the living will. Then it must be witnessed by 2 qualified adults and either be notarized or be certified by a clerk or assistant clerk of a Superior Court in North Carolina.

The only people who **CANNOT** witness your signature are: 1) Anyone related to you or your spouse within the third degree (grandparents, parents, children or grandchildren); 2) Anyone who is entitled to any portion of your estate; 3) Your attending physician, licensed health care providers who are paid employees of your attending physician; 4) Paid employees of a health facility, nursing home or adult care home in which you reside; or 5) Any person who has any claim against your estate.

HEALTH CARE POWER OF ATTORNEY

What is a Health Care Power of Attorney (HCPA)?

A HCPA is a legal document which allows you (the "principal") to appoint another individual (the "attorney-in-fact" or "agent") to make medical and/or mental health decisions for you if you should become temporarily or permanently unable to make those decisions yourself. The person you choose as your attorney-in-fact does not have to be a lawyer.

Who can I appoint to be my Agent?

You can appoint almost any adult to be your agent. You should select a person(s) knowledgeable about your wishes, values, religious beliefs, in whom you have trust and confidence and who knows how you feel about health care. You should discuss the matter with the person(s) you have chosen and make sure that they understand and agree to accept the responsibility.

You can select a member of your family, such as your spouse, child, brother or sister, or a close friend. If you select your spouse and the marriage is dissolved or annulled, the appointment of your spouse as your agent or alternate agent is revoked.

The only person who **CANNOT** be appointed as your agent is any person who is providing you with health care and whom you are paying for that health care.

When does the HCPA take effect?

The HCPA only becomes effective when you are temporarily or permanently unable to make your own health care decisions and your agent consents to start making those decisions. Your agent will begin making decisions after your doctors have decided that you are no longer able to make them. Remember, as long as you are capable of making your own treatment decisions, you have the right to do so.

What decisions can my Agent make?

Unless you limit his or her authority in the HCPA, your agent will be able to make almost every treatment decision in accordance with accepted medical practice that you could make, if you were able to do so. If your wishes are not known or cannot be determined, your agent has the duty to act in your best interest in the performance of his or her duties. These decisions can include authorizing, refusing or withdrawing treatment, even if it means that you will die. As you can see, the appointment of an agent is a very serious decision on your part.

Can there be more than one Agent?

Yes. While you are not required to do so, you may designate alternates who may also act for you, if your primary agent is unavailable, unable or unwilling to act. Your alternate agent(s) will have the same decision-making powers as the primary agent.

Can I appoint more than one person to share the responsibility of being my Agent?

You should appoint only **ONE** person to be your primary agent. Any others that

you want to be involved with your health care decisions should be appointed as your alternates. If two or more people are given equal authority and they disagree on a health care decision, one of the most important purposes of the HCPA--to clearly identify who has the authority to speak for you--will be defeated. If you are afraid of offending people close to you by choosing one over another to be your agent, ask them to decide among themselves who will be your primary agent and select the others as alternates.

Can my Agent be legally liable for decisions made on my behalf?

No. Your health care agent or your alternate agents cannot be held liable for treatment decisions made in good faith on your behalf. Also, he or she cannot be held liable for costs incurred for your care just because he or she is your agent.

Can my Agent resign?

Yes. Your agent and your alternates can resign at any time by giving written notice to you, your doctor or the hospital or nursing home where you are receiving care.

Does the HCPA have to be signed and witnessed?

Yes. You must sign (or have someone sign the document in your presence and at your direction, if you are unable to sign) and date the document. Then it must be witnessed by 2 qualified adults and notarized.

The only people who **CANNOT** witness your signature are: 1) Any person who is related to you or your spouse by blood or marriage within the third degree (grandparents, parents, children or grandchildren); 2) Any person who is entitled to any portion of your estate; 3) Your attending physician or your mental health treatment provider; 4) A paid employee of your attending physician or mental health treatment provider; 5) A paid employee of a health care facility, nursing home or group-care home in which you are a patient or residing; or 6) Any person who has a claim against any portion of your estate.

How is the HCPA different from the Living Will?

A living will only applies if you are terminally ill or if you are in a persistent vegetative state and unless you write in other specific instructions, it only tells your doctor what you do **NOT** want.

The HCPA allows you to appoint someone to make health care decisions for you if you cannot make them. It covers all health care situations in which you are incapable of making decisions for yourself. It also allows you to give specific instructions to your agent about the type of care you want to receive.

The HCPA allows your agent to respond to medical situations that you might not have anticipated and to make decisions for you with knowledge of your values and wishes.

Since the HCPA is more flexible, it is the advance directive most people choose. Some people, however, do not have someone whom they trust or who knows their values and preferences. These people should consider creating a living will.

ADVANCE INSTRUCTION FOR MENTAL HEALTH TREATMENT

What is an Advance Instruction for Mental Health Treatment (AIMHT)?

An AIMHT is a legal document which allows you to tell your doctor and other health care providers about your preferences and instructions regarding your mental health care treatment, if you are no longer able to make these decisions yourself.

What is "Mental Health Treatment"?

Mental health treatment is defined by North Carolina law to include:

1)Electroconvulsive treatment (Examples might include electroshock therapy or drugs which can produce convulsions); 2) Psychoactive drugs (drugs which work on your central nervous system); and 3) Admission to and retention in a facility for the care or treatment of mental illness.

When does an AIMHT go into effect?

An AIMHT goes into effect when your doctor or mental health care provider determines that you no longer understand the nature and consequences of proposed mental health treatment and that you cannot make decisions about that treatment.

Does the AIMHT have to be signed and witnessed?

Yes. You must sign (or have someone sign the document in your presence or at your direction, if you are unable to sign) and date the document. Then it must be witnessed by 2 qualified adults and notarized.

The following people **CANNOT** witness your signature of the AIMHT:

1) Your attending physician or mental health service provider;

2) An employee of your attending physician or mental health service provider;

3) An owner, operator or employee of an owner or operator of a health care facility in which you are a patient or a resident; or

4) Anyone related to you or your spouse within the third degree (grandparents, parents, children or grandchildren).

Where can I get an AIMHT form?

Because of space limitations, the AIMHT form suggested by North Carolina law has not been provided in this booklet. You should contact your doctor or other health care provider to get a copy of the suggested document, or you can send $3.00 and a self-addressed stamped envelope to Professional Media Resources, P.O. Box 460380, St. Louis, MO 63146 and the document will be mailed to you.

NORTH CAROLINA ADVANCE DIRECTIVE FOR A NATURAL DEATH ("LIVING WILL")

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

GENERAL INSTRUCTIONS

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

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

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

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

MY DESIRE FOR A NATURAL DEATH

I, _____, being of sound mind, desire that, as specified below, my life not be prolonged by life-prolonging measures:

1. When my directives apply:

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

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

_____ I have an incurable or irreversible condition that will result in my death within a relatively short period of time.

_____ I become unconscious and my health care providers determine that, to a high degree of medical certainty, I will never regain my consciousness.

_____ 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

_____ may withhold or withdraw life-prolonging measures.

_____ 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:

_____ 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

_____ 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

_____ 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 **override** instructions my health care agent gives about prolonging my life.

_____ Follow Health Care Agent: My health care agent has 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 any of 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 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.

DECLARANT SIGNATURE

This the _____ day of _____, 20 _____.

Signature:_____ Print Name:_____

WITNESS SIGNATURES

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) a paid employee of the declarant's attending physician, (2) nor a paid employee of the health facility in which the declarant is a patient, or (3) a paid 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: _____

NOTARY

_____ COUNTY, _____ STATE

Sworn to (or affirmed) and subscribed before me this day by _____
(Declarant)

_____ and _____
(Witness) (Witness)

Date: _____ Official Seal

Signature of Notary Public: _____

My commission expires: _____

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

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

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

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

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

1. DESIGNATION OF HEALTH CARE AGENT

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

A. Name: _____ A. Name: _____

Home Address: _____ Home Address: _____

Cell Phone: _____ Cell Phone: _____

Home Telephone: _____ Home Telephone: _____

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

2. EFFECTIVENESS OF APPOINTMENT

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

1. _____ (Physician) 2. _____ (Physician)

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

3. REVOCATION

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

4. GENERAL STATEMENT OF AUTHORITY GRANTED

Subject to any restrictions set forth in Section 6 below, I grant to my health care agent full power and authority to make and carry out all health care decisions for me. These decisions include, but are not limited to:

A. Requesting, reviewing, and receiving any information, verbal or written, regarding my physical or mental health, including, but not limited to, medical and hospital records, and to consent to the disclosure of this information. B. Employing or discharging my health care providers. C. Consenting to and authorizing my admission to and discharge from a hospital, nursing or convalescent home, hospice, long-term care facility, or other health care facility. D. Consenting to and authorizing my admission to and retention in a facility for the care or treatment of mental illness. E. Consenting to and authorizing the administration of medications for mental health treatment and electroconvulsive treatment (ECT) commonly referred to as "shock treatment." F. Giving consent for, withdrawing consent for, or withholding consent for, X-ray, anesthesia, medication, surgery, and all other diagnostic and treatment procedures ordered by or under the authorization of a licensed physician, dentist, podiatrist, or other health care provider. This authorization specifically includes the power to consent to measures for relief of pain. G. Authorizing the withholding or withdrawal of life-prolonging measures. H. Providing my medical information at the request of any individual acting as my attorney-in-fact under a durable power of attorney or as a Trustee or successor Trustee under any Trust Agreement of which I am a Grantor or Trustee, or at the request of any other individual whom my health care agent believes should have such information. I desire that such information be provided whenever it would expedite the prompt and proper handling of my affairs or the affairs of any person or entity for which I have some responsibility. In addition, I authorize my health care agent to take any and all legal steps necessary to ensure compliance with my instructions providing access to my protected health information. Such steps shall include resorting to any and all legal procedures in and out of courts as may be necessary to enforce my rights under the law and shall include attempting to recover attorneys' fees against anyone who does not comply with this health care power of attorney. I. To the extent I have not already made valid and enforceable arrangements during my lifetime that have not been revoked, exercising any right I may have to authorize an autopsy or direct the disposition of my remains. J. Taking any lawful actions that may be necessary to carry out these decisions, including, but not limited to: (i) signing, executing, delivering, and acknowledging any agreement, release, authorization, or other document that may be necessary, desirable, convenient, or proper in order to exercise and carry out any of these powers: (ii) granting releases of liability to medical providers or others: and (iii) incurring reasonable costs on my behalf related to exercising these powers, provided that this health care power of attorney shall not give my health care agent general authority over my property or financial affairs.

5. SPECIAL PROVISIONS AND LIMITATIONS

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

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.

A.Limitations about Artificial Nutrition or Hydration.

In exercising the authority to make health care decisions on my behalf, my health care agent:

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

_____ 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:_____

B. Limitations Concerning Health Care Decisions.

NOTE : DO NOT initial unless you insert a limitation.

_____ 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.) _____

C. Limitations Concerning Mental Health Decisions.

NOTE: DO NOT initial unless you insert a limitation.

_____ 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.)

_____

D. Advance Instruction for Mental Health Treatment.

NOTE: DO NOT initial unless you insert a limitation.

_____ (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):

_____

E. Autopsy and Disposition of Remains.

NOTE: DO NOT initial unless you insert a limitation.

_____ 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 approprtiate such as: limiting the grant of authority and the scope of authority, or instructions regarding burial or cremation): _____

_____

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:

_____ donate any needed organs or parts; or

_____ donate only the following organs or parts: _____

NOTE: DO NOT INITIAL BOTH BLOCKS ABOVE.

_____ donate my body for anatomical study if needed.

_____ 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 DOCUMENT 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 Section1, 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. 35-A-1201(a)(5).

8. RELIANCE OF THIRD PERSON PARTIES ON HEALTH CARE AGENT

A. No person who relies in good faith upon the authority of or any representations by my health care agent shall be liable to me, my estate, my heirs, successor, assigns, or personal representatives, for actions or omissions in reliance on that authority or those representations.

B. The powers conferred on my health care agent by this document may be exercised by my health care agent alone, and my health care agent's signature or action taken under the authority granted in this document may be accepted by persons as fully authorized by me and with the same force and effect as if I were personally present, competent, and acting on my own behalf. All acts performed in good faith by my health care agent pursuant to this power of attorney are done with my consent and shall have the same validity and effect as if I were present and exercised the powers myself, and shall inure to the benefit of and bind me, my estate, my heirs, successors, assigns, and personal representatives. The authority of my health

care agent pursuant to this power of attorney shall be superior to and binding upon my family, relatives, friends, and others.

9. MISCELLANEOUS PROVISIONS

A. Revocation of Prior Powers of Attorney. I revoke any prior health care power of attorney. The preceeding sentence is not intended to revoke any general powers of attorney, some of the provisions of which may relate to health care; however, this power of attorney shall take precedence over any health care provisions in any valid general power of attorney I have not revoked.

B. Jurisdiction, Severability, and Durability. This Health Care Power of Attorney is intended to be valid in any jurisdiction in which it is presented. The powers delegated under this power of attorney are severable, so that the invalidity of one or more powers shall not affect any others. This power of attorney shall not be affected or revoked by my incapacity or mental incompetence.

C. Health Care Agent Not Liable. My health care agent and my health care agent's estate, heirs, successors, and assigns are hereby released and forever discharged by me, my estate, my heirs, successors, assigns, and personal representatives from all liability and from all claims or demands of all kinds arising out of my health care agent's acts or omissions, except for my health care agent's willful misconduct or gross negligence.

D. No Civil or Criminal Liability. No act or omission of my health care agent, or of any other person, entity, institution, or facility acting in good faith in reliance on the authority of my health care agent pursuant to this Health Care Power of Attorney shall be considered suicide, nor the cause of my death for any civil or criminal purposes, nor shall it be considered unprofessional conduct or as lack of professional competence. Any person, entity, institution, or facility against whom criminal or civil liability is asserted because of conduct authorized by this Health Care Power of Attorney may interpose this document as a defense.

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.

PRINCIPAL SIGNATURE

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.

_____ _____
(Signature) (Date of Birth)

This the _____ day of _____, 20 _____

WITNESS SIGNATURES

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, or a licensed health care provider or mental health treatment provider who is (1) a paid employee of the principal's attending physician or mental health treatment provider, (2) a paid employee of the health facility in which the principal is a patient, or (3) am a paid 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: _____

NOTARY

_____ COUNTY, _____ STATE

Sworn to (or affirmed) and subscribed before me this day by _____
(Principal)

_____ and _____
(Witness) (Witness)

Date: _____ Official Seal

Signature of Notary Public: _____

My commission expires: _____

A SUMMARY STATEMENT OF HEALTH CARE POLICIES REGARDING PATIENTS' RIGHTS OF SELF-DETERMINATION

(Since a summary like this cannot answer all possible questions or cover every circumstance, you should discuss any remaining questions with a representative of this health care facility.)

1. Prior to the start of any procedure or treatment, the physician shall provide the patient with whatever information is necessary for the patient to make an informed judgment about whether the patient does or does not want the procedure or treatment performed. Except in an emergency, the information provided to the patient to obtain the patient's consent shall include, but not necessarily be limited to, the intended procedure or treatment, the potential risks, and the probable length of disability. Whenever significant alternatives of care or treatment exist, or when the patient requests information concerning alternatives, the patient shall be given such information. The patient shall have the right to know the person responsible for all procedures and treatments.

2. The patient may refuse medical treatment to the extent permitted by law. If the patient refuses treatment, the patient will be informed of significant medical consequences that may result from such action.

3. The patient will receive written information concerning his or her individual rights under state law to make decisions concerning medical care.

4. The patient will be given information and the opportunity to make advance directives--including, but not limited to, a North Carolina Declaration of a Desire for a Natural Death, a Health Care Power of Attorney and an Advance Instruction for Mental Health Treatment.

5. The patient shall receive care regardless of whether or not the patient has or has not made an advance directive.

6. The patient shall have his or her advance directive(s), if any has been created, made a part of his or her permanent medical record.

7. The patient shall have all of the terms of his or her advance directive(s) complied with by the health care facility and caregivers to the extent required or allowed by North Carolina law.

8. The patient shall be transferred to another doctor or health care facility if his or her doctor(s), or agent of his or her doctor(s), or the health care facility cannot respect the patient's advance directive requests as a matter of "conscience".

9. The patient shall receive the name, phone number and address of the appropriate state agency responsible for receiving questions and complaints about these advance directive policies.

WALLET CARDS FOR NORTH CAROLINA ADVANCE DIRECTIVES

Complete and cut out the cards below. Put the cards in the wallet or purse you carry most often, along with your driver's license or health insurance card. **NOTE: Please be sure to make a copy of page 4 of 4 (the reverse page of this one) before cutting these wallet cards or you will be cutting out part of the last page of the Health Care Power of Attorney.**

ATTN: NORTH CAROLINA HEALTH CARE PROVIDERS

I have created the following Advance Directives:
(Check one or more)

_____ Declaration of a Desire for a Natural Death
_____ Health Care Power of Attorney
_____ Advance Instructions for Mental Health Treatment

Please contact _____ (Name)

at _____ (Address)

and _____ (Telephone) for more information.

_____ (Date) _____ (Signature)

NORTH CAROLINA ORGAN DONOR CARD

I have given my agent(s) authority to donate any or all of my organs in my Health Care Power of Attorney dated _____.

Please contact _____ (Name)

at _____ (Address)

and _____ (Telephone) for more information.

_____ (Date) _____ (Signature)

INDIVIDUALS AND ORGANIZATIONS MAY OBTAIN ADDITIONAL COPIES OF THIS BOOKLET BY VISITING OUR WEBSITE AT: WWW.ADVDIR.COM