ADVANCE DIRECTIVE FOR HEALTH CARE

Print your Name Here: ______________________

If I am incapable of making an informed decision regarding my health care, I direct my health care providers to follow my instructions below.

I. LIVING WILL

If my attending physician and another physician determine that I am no longer able to make decisions regarding my medical treatment, I direct my attending physician and other health care providers, pursuant to the Oklahoma Advance Directive Act, to follow my instructions as set forth below.

(1) If I have a terminal condition, that is, an incurable and irreversible condition that even with the administration of life-sustaining treatment will, in the opinion of the attending physician and another physician, result in death within six (6) months:

Initial selection and include time limits if desired.

_____ I direct that I be given life-sustaining treatment and, if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

Optional: ___ Discontinue life-sustaining treatment, artificial nutrition and hydration after ______ days.

_____ I direct that my life not be extended by life-sustaining treatment, except that if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

Optional: ___ Discontinue artificial nutrition and hydration after ______ days.

_____ I direct that my life not be extended by life-sustaining treatment, including artificially administered nutrition and hydration.

_____ See my more specific instructions in paragraph (4) below which modify this selection. (Initial if applicable)

(2) If I am persistently unconscious, that is, I have an irreversible condition, as determined by my attending physician and another physician, in which thought and awareness of self and environment are absent:

Initial selection and include time limits if desired.

_____ I direct that I be given life-sustaining treatment and, if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

Optional: ___ Discontinue life-sustaining treatment, artificial nutrition and hydration after ______ days.

_____ I direct that my life not be extended by life-sustaining treatment, except that if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

Optional: ___ Discontinue artificial nutrition and hydration after ______ days.

_____ I direct that my life not be extended by life-sustaining treatment, including artificially administered nutrition and hydration.

_____ *See my more specific instructions in paragraph (4) below which modify this selection. (Initial if applicable)*

(3) If I have an end-stage condition, that is a condition caused by injury, disease or illness, which results in severe and permanent deterioration indicated by incompetency and complete physical dependency for which treatment of the irreversible condition would be medically ineffective:

Initial selection and include time limits if desired.

_____ I direct that I be given life-sustaining treatment and, if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

Optional: ___ Discontinue life-sustaining treatment, artificial nutrition and hydration after ______ days.

_____ I direct that my life not be extended by life-sustaining treatment, except that if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

Optional: ___ Discontinue artificial nutrition and hydration after ______ days.

_____ I direct that my life not be extended by life-sustaining treatment, including artificially administered nutrition and hydration.

_____ See my more specific instructions in paragraph (4) below which modify this selection. (Initial if applicable)

(4) OTHER. Here you may:

(a) Describe other conditions in which you would want life-sustaining treatment or artificially administered nutrition and hydration provide, withheld or withdrawn, and/or

(b) Give more specific instructions about your wishes concerning life-sustaining treatment or artificially administered nutrition and hydration if you have a terminal condition, are persistently unconscious, or have an end-stage condition,

____

____

____

____

______ (Initial)

II. MY APPOINTMENT OF MY HEALTH CARE PROXY

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If my attending physician and another physician determine that I am no longer able to make decisions regarding my medical treatment, I direct my attending physician and other health care providers pursuant to the Oklahoma Advance Directive Act to follow the instructions of the individuals listed below who I appoint as my health care proxy to make health care decisions for me as authorized in this document. My health care proxy is authorized to make whatever medical treatment decisions I could make if I were able, except that decisions regarding life-sustaining treatment and artificially administered nutrition and hydration can be made by my health care proxy or alternate health care proxy only as I have indicated in the foregoing sections. If more than one is listed, they are to serve in the order chosen. If the first is unavailable then the decisions of the next should be followed, and so on.

1.____

2.____

3.____

4.____

III. ANATOMICAL GIFTS

Initial One:

_________ I chose to not make any anatomical or organ gifts.

Or

__________I authorize my Healthcare Proxy make anatomical gifts on my behalf for the limited purpose of transplantation or therapy, which shall take effect upon my death.

Or

________Pursuant to the provisions of the Uniform Anatomical Gift Act, I direct that at the time of my death my entire body or designated body organs or body parts be donated for the purpose of:
(Initial all that apply)

If you are choosing to donate you may make more specific choices here.

Pursuant to the provisions of the Uniform Anatomical Gift Act, I direct that at the time of my death my entire body or designated body organs or body parts be donated for the purpose of:
(Initial all that apply)

_______ transplantation

_______ therapy

_______ advancement of medical science or research or education.

_______ advancement of dental science or research or education.

Death means either irreversible cessation of circulatory and respiratory functions or irreversible cessation of all functions of the entire brain, including the brain stem. I specifically donate:

☐ My entire body; or

☐ The following organs or body parts

☐ lungs	☐ liver	☐ pancreas	☐ heart
☐ kidneys	☐ brain	☐ skin	☐ bones/marrow
☐ bloods/fluids	☐ tissues	☐ arteries	☐ eyes/cornea/lens

____
(initials)

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

Subject to any limitations in this document, my health care proxy has the power and authority to do all of the following:

(1) Request, review, and receive, to the extent I could do so individually, any information, verbal or written, regarding my physical or mental health, including, but not limited to, 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), 42 U.S.C. 1320d and 45 CFR 160-164, as well as 63 O.S. Supp. 2007, §1-502.2. I hereby 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 health care proxy, without restriction, all of my individually identifiable health information and medical records regarding any past, present, or future medical or mental health condition. **The information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease.** This authority given my health care proxy shall supersede any other agreement which I may have made with my health care providers to restrict access to or disclosure of my individually identifiable health information. This authority given my health care proxy shall be effective immediately, 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.

(2) Execute on my behalf any releases or other documents that may be required in order to obtain this information; and

(3) Consent to the disclosure of this information.

V. GENERAL PROVISIONS

. I understand that I must be eighteen (18) years of age or older to execute this form

. I understand that my witnesses must be eighteen (18) years of age or older and shall not be related to me and shall not inherit from me.

. I understand that if I have been diagnosed as pregnant and that diagnosis is known to my attending physician, I will be provided with life-sustaining treatment and artificially administered hydration and nutrition unless I have, in my own words, specifically authorized that during a course of pregnancy, life-sustaining treatment and/or artificially administered hydration and/or nutrition shall be withheld or withdrawn,

In the absence of my ability to give directions regarding the use of life-sustaining procedures, it is my intention that this advance directive shall be honored by my family and physicians as the final expression of my legal right to refuse medical or surgical treatment including, but not limited to, the administration of any life-sustaining procedures, and I accept the consequences of such choice or refusal.

This advance directive shall be in effect until it is revoked. I understand that I may revoke this advance directive at any time. I understand and agree that if I have any prior directives, and if I sign this advance directive, my prior directives are revoked. I understand the full importance of this advance directive and I am emotionally and mentally competent to make this advance directive.

I understand that my physician(s) shall make all decisions based upon his or her best judgment applying with ordinary care and diligence the knowledge and skill that is possessed and used by members of the physician's profession in good standing engaged in the same field of practice at that time, measured by national standards.

Date: ______________________

____

Signature

Print Name: _____________________________

Witnesses: This must be witnessed by two individuals who are eighteen (18) years of age or older who are not legatees, devisees, or heirs at law.

This advance directive was signed in my presence.

____

»[signature – please print name under this line]«

Print Name: _______________________________ Address: _________________________________

____

»[signature – please print name under this line]«

Print Name: _______________________________ Address: _________________________________

Form provided by:

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After completion please provide copies to your doctor, hospital, and family members. If you live in a facility such as a nursing home, or assisted living center they should receive a copy as well.