

**HEALTH CARE DIRECTIVE LIVING WILL and/or POWER OF ATTORNEY – NETWORK**

I, \_\_\_\_\_ want everyone who cares for me to know what health care I want, when I cannot let others know what I want.

**SECTION 1:**

I want my doctor to try treatments that may get me back to an acceptable quality of life. However, if my quality of life becomes unacceptable to me and my condition will not improve (is irreversible), I direct that all treatments that extend my life be withdrawn.

A quality of life that is unacceptable to me means (check all that apply)

- Unconscious (chronic coma or persistent vegetative state)
- Unable to communicate my needs
- Unable to recognize family or friends
- Total or near total dependence on other for care
- Other: \_\_\_\_\_

Check only one:

- Even if I have the quality of life described above, I still wish to be treated with food and water by tube of intravenously (IV).
- If I have the quality of life described above, I do NOT wish to be treated with food and water by tube or intravenously (IV).

**SECTION 2:**

Some people do NOT want certain treatments under any circumstance, even if they might recover.

Check the treatments below that you do NOT want under any circumstances:

- Cardiopulmonary Resuscitation (CPR)
- Ventilation (breathing machine)
- Feeding tube
- Dialysis
- Other: \_\_\_\_\_

**SECTION 3:**

When I am near death, it is important to me that: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
(Such as hospice care, place of death, funeral arrangements, cremation or burial preferences.)

Initials \_\_\_\_\_ Date \_\_\_\_\_

**See page 3 for witness or notary public signatures**

Talk about this form with the person you have chosen to make decisions for you, your doctor(s), your family and friends. Give each of them a copy of this form. Take a copy whenever you go to the hospital or on a trip. Review this form often. You can cancel or change this form at any time.

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SECTION 4: MEDICAL HEALTH CARE POWER OF ATTORNEY and / or MENTAL HEALTH AUTHORITY

A. MEDICAL POWER OF ATTORNEY:

It is important to choose someone to make healthcare decisions for you when you cannot. Tell the person (agent) you choose what you would want. The person you choose has the right to make any decision to ensure that your wishes are honored. If you DO NOT choose someone to make decisions for you, write NONE in the line for the agent's name.

I, \_\_\_\_\_, as principal,

designate \_\_\_\_\_ as my agent for all matters relating to my health and including, without limitation, full power to give or refuse consent to all medical, surgical, hospital and related health care. This power of attorney is effective on my inability to make or communicate health care decisions. All of my agent's actions under this power during any period when I am unable to make or communicate health care decisions or when there is uncertainty whether I am dead or alive have the same effect on my heirs, devisees and personal representatives as if I were alive, competent and acting for myself.

B. WITH MENTAL HEALTH AUTHORITY:

- I do NOT wish to designate or appoint a Health Care Power of Attorney with Mental Health Authority.
- My appointed agent without limitation has full power to give or refuse mental health treatment.

\_\_\_\_\_ By initialing here, I specifically consent to giving my agent the power to admit me to an inpatient partial psychiatric hospitalization program if ordered by my physician.

\_\_\_\_\_ By initialing here, this Health Care Directive including Mental Health Care Power of Attorney may not be revoked if I am incapacitated.

Print agent ADDRESS and PHONE:

\_\_\_\_\_

ALTERNATE: If my agent is unwilling or unable to serve or continue to serve, I hereby appoint:

\_\_\_\_\_ as my agent.

Print alternate agent ADDRESS and PHONE:

\_\_\_\_\_

I intend for my agent to be treated as I would regarding the use and disclosure of 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 (aka HIPPA), 42 USC 1420D and 45 DVR 160-164.

Initials: \_\_\_\_\_ Date: \_\_\_\_\_

SIGN HERE for the Health Care (Medical) Power of Attorney and Mental Health Authority designation.

Patient Name PRINTED: \_\_\_\_\_

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

**SIGNATURE OF WITNESSES OR NOTARY PUBLIC:**

NOTE: Two adult witnesses OR a Notary Public must witness the signing of this document and then sign it. The witnesses or Notary Public CANNOT be anyone who is: (a) under the age of 18; (b) related to you by blood, adoption, or marriage; (c) entitled to any part of your estate; (d) appointed as your representative; or (e) involved in providing your health care at the time this form is signed.

- A. Witnesses: By signing below, I certify that I witnessed the signing of this document by the Principal. The person who signed this Health Care Directive Living Will and/or Power of Attorney and Mental Health Authority appeared to be of sound mind and under no pressure to make specific choices or sign the document. I understand the requirements of being a witness and I confirm the following:
- I am not currently designated to make medical decisions for this person.
  - I am not directly involved in administering health care to this person.
  - I am not entitled to any portion of this person's estate upon his or her death under a will or operation by law.
  - I am not related to this person by blood, marriage, or adoption.

1. Witness Name (printed) \_\_\_\_\_

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

Address: \_\_\_\_\_

2. Witness Name (printed) \_\_\_\_\_

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

Address: \_\_\_\_\_

**Notary Public** (NOTE: If a witness signs your form, you DO NOT need a notary to sign):

STATE OF ARIZONA) ss  
COUNTY OF \_\_\_\_\_)

The undersigned, being a Notary Public certified in Arizona, declares that the person making this Health Care Directive Living Will and/or Power of Attorney has dated and signed or marked it in my presence and appears to me to be of sound mind and free from duress. I further declare I am not related to the person signing above by blood, marriage or adoption, or a person designated to make medical decisions on his/her behalf. I am not directly involved in providing health care to the person signing. I am not entitled to any part of his/her estate under a will now existing or by operation of law. In the event the person acknowledging this Health Care Directive Living will and/or Power of Attorney is physically unable to sign or mark this document, I verify that he/she directly indicated to me that this Health Care Directive Living will and/or Power of Attorney expresses his/her wishes and that he/she intends to adopt the Health Care Directive Living will and/or Power of Attorney at this time.

WITNESS MY HAND AND SEAL this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_.

Notary Public \_\_\_\_\_ My Commission Expires: \_\_\_\_\_