IDAHO DURABLE POWER OF ATTORNEY FOR HEALTHCARE AND LIVING WILL

Print Name: _____ **Date**: _____

Address: _____ **Birth Date:** _____

DURABLE POWER OF ATTORNEY FOR HEALTHCARE

This portion of my Advance Directive creates a durable power of attorney for healthcare. This power of attorney will remain in effect if I become incapacitated and shall be effective **only** when I am unable to communicate and lack decisional capacity.

For the purposes of this Directive, "healthcare decision" means:

- Consent
- Refusal of consent; or
- Withdrawal of consent

to any care, treatment, or procedure to maintain, diagnose or treat an individual's medical condition.

1. **DESIGNATION OF AGENT**. I designate and appoint the following individual as my healthcare agent to make healthcare decisions for me as authorized in this Directive:

Name of Healthcare Agent: _____

Telephone Number of Healthcare Agent: _____

Address: _____

2. **DESIGNATION OF ALTERNATE AGENTS**. If the person designated as my healthcare agent in paragraph 1:

- Is not available or becomes ineligible to act as my agent to make a healthcare decision for me; or
- Loses the mental capacity to make healthcare decisions for me; or
- If I revoke that person's designation or authority to act as my agent to make healthcare decisions for me,

then I designate and appoint the following person to serve as my agent to make healthcare decisions for me as authorized in this Directive (Y*ou are not required to designate any alternate agents, but you may do so. Any alternate agent you designate will be able to make the same healthcare decisions as the agent you designated in paragraph 1 above, in the event that person is unable or ineligible to act as your agent.)*

A. Name of First Alternate Healthcare Agent: _____

Telephone Number: _____

Address: _____

B. Name of Second Alternate Healthcare Agent: _____

Telephone Number: _____

Address: _____

If any of the agents designated above is my spouse, and our marriage is dissolved (divorce or annulment) after creation of this Directive, appointment of that agent is automatically revoked as of the date of the dissolution.

None of the following may be designated as your agent or alternate agent:

- *Your treating healthcare provider;*
- *A non-relative employee of your treating healthcare provider;*
- *An operator of a community care facility; or*
- *A non-relative employee of an operator of a community care facility.*

3. **GENERAL STATEMENT OF AUTHORITY GRANTED**. I hereby grant to my agent full authority to make healthcare decisions for me to the same extent that I could make such decisions for myself if I had the capacity to do so. My agent shall make healthcare decisions that are consistent with my desires as stated in this Directive or otherwise made known to my agent verbally or in writing. This includes, but is not limited to, my desires concerning obtaining, refusing or withdrawing life-sustaining care, treatment, procedures. This authority includes following my desires as stated in a living will or similar document executed by me.

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

A. General Grant of Power and Authority. Subject to any limitations in this Directive, my agent has the power and authority to do all of the following:

- Request, review and receive any information, verbal or written, regarding my physical or mental health including, but not limited to, medical and hospital records;
- Execute on my behalf any releases or other documents that may be required in order to obtain this information;
- Consent to the disclosure of this information; and
- Consent to the donation of any of my organs for medical purposes.

B. HIPAA Release Authority. My agent shall 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. 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 through 164. I authorize any physician, healthcare professional, dentist, health plan, hospital, clinic, laboratory, pharmacy, or other covered healthcare provider, any insurance company, and the Medical Information Bureau, Inc. or other healthcare 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 agent, without restriction, all of my individually identifiable health information and medical records regarding any past, present or future medical or mental health condition, including all information relating to the diagnosis of HIV/AIDS, sexually transmitted diseases, mental illness, and drug or alcohol abuse. The authority given my agent shall supersede any other agreement that I may have made with my healthcare providers to restrict access to or disclosure of my individually identifiable health information.

5. **SIGNING DOCUMENTS, WAIVERS AND RELEASES**. When necessary to implement the healthcare decisions that this Directive authorizes my agent to make, my agent has the authority to execute on my behalf all of the following:

- Documents titled, or purporting to be, a "Refusal to Permit Treatment" and/or a "Leaving Hospital against Medical Advice"; and
- Any necessary waiver or release from liability required by a hospital or physician.

6. **PRIOR DESIGNATIONS REVOKED**. I revoke any prior durable power of attorney for healthcare.

LIVING WILL
Directive to Withhold or to Provide Treatment

This Advance Directive states my choices about life-sustaining medical treatment at the end of life. This Directive shall be effective only if I am unable to communicate my instructions and:

A. I have an incurable injury, disease, illness or condition and a medical doctor who has examined me has certified:

i. That such injury, disease, illness or condition is terminal; and
ii. That the application of artificial life-sustaining procedures would serve only to prolong artificially my life; and
iii. That my death is imminent, whether or not artificial life-sustaining procedures are utilized;

OR

B. I have been diagnosed as being in a persistent vegetative state.

IF I AM IN ONE OF THE ABOVE SITUATIONS, my choices are as follows *(Choose Box 1, 2 or 3 below, check the box and initial the line after the box you checked).*

Regardless of the box chosen below, pain and symptom management (comfort care) will be provided.

1 ☐ _____ If my death is imminent, I do not want life-sustaining medical treatment or procedures to be started and, if already started, I want all such treatment and procedures to be withdrawn, including withdrawal of artificial nutrition (such as feeding tube) and artificial hydration (such as IV).

OR

2 ☐ _____ If my death is imminent, I do not want any artificial life-sustaining medical treatment, care or procedures except for artificial nutrition and artificial hydration as follows:

Check one box and initial the line after such box:

A. ☐ _____ Only artificial hydration;

B. ☐ _____ Only artificial nutrition;

C. ☐ _____ Both artificial hydration and nutrition.

OR

3 ☐ _____ If my death is imminent, I want all medical treatment, care and procedures necessary to sustain my life, including artificial nutrition and hydration.

OPTIONAL SPECIAL PROVISIONS

The following are additional statements of my wishes. *Check all boxes that apply and initial on the line after such box:*

☐ _____ If I have a medical condition from which I am not imminently dying, and from which I will not likely recover, am unable to think or communicate and am dependent on others for my care, I do not want life-sustaining medical treatment or procedures to be started. If already started, I want all such treatment and procedures to be withdrawn, including withdrawal of artificial nutrition (such as feeding tube) and artificial hydration (such as IV). In such condition, I want care to be focused on my comfort.

☐ _____ Other situations as described in the box below *(If needed, attach and sign additional pages):*

Some examples of things that may be included here are: no admission to Intensive Care Unit; resuscitation preference*; willingness to live permanently in a nursing home; people you do not want involved in your medical decisions; limitations to treatment options, including time limits; willingness to have a permanent feeding tube; funeral and burial wishes; organ/body donation, etc.

**NOTE: If you wish to be DNR (Do Not Resuscitate), you must complete a POST form. Ask your physician, advanced practice nurse or physician assistant to complete a POST form with you. A POST form contains specific medical orders for individuals with a serious illness.*

IDAHO POST FORM VERIFICATION. *Check one box and initial the line after the box you checked:*

☐ _____ I have completed a Physician Orders for Scope of Treatment (POST) form that contains directions that may be more specific than, but are compatible with, this Directive. I hereby approve of those Orders and make them a part of this Directive.

OR

☐ _____ I have not completed a Physician Orders for Scope of Treatment (POST) form. If I complete a POST form at a later date, then this Living Will shall be deemed modified to be compatible with the terms of the POST form.

DATE AND SIGNATURE OF PRINCIPAL. *You must sign this Durable Power of Attorney for Healthcare and Living Will in order for it to be valid.*

I understand the full importance of these Directives and am mentally competent to make these Directives. No participant in the making of these Directives or in its being carried into effect shall be held responsible in any way for complying with my directions.

The authority given my agent has no expiration date and shall expire only in the event that I revoke the authority in writing.

I sign my name below to this Idaho Durable Power of Attorney for Healthcare and Living Will on the date at the beginning of this document.

_____

Signature