**Utah Advance Health Care Directive Utah Advance Health Care Directive *(Pursuant to Utah Code Section 75-2a-117, effective 2009 )\****

**Part I: *Allows you to name another person to make health care decisions for you when you***

**Part I:**

***cAalnlonwost myoaukteodneacmisieonans ootrhseprepaekrsfor ytoumrsaeklef.health care decisions for you when you***

**Part II: *Acallnonwost ymoaukteo dreciosriodnysoour swpiesahkesfoarboyouut rhseealfl.th care in writing.***

**Partt III:: *TAelllswysoyuohuotwo rtoecroervdokyoeuorr wchisahnegseatbhoius tdhireeaclttihvec.are in writing.***

**Partt IVII::**

***MTealklseysoyuouhrodwirteocrtievveokleegoarl. change this directive.***

**Part IV: *Makes your directive legal.***

**My Personal Information**

**My Personal Information**

Name: Street Address:

City, State, Zip Code:

Telephone: ( ) Birth Date:

Cell Phone: ( )

**A. No Agent**

**Part I: My Agent (*Health Care Power of Attorney)***

**Part I: My Agent (*Health Care Power of Attorney)***

*If you do not want to name an agent, initial the box below, then go to Part II; do not name an agent in B*

*or C below. No one can force you to name an agent.*

**I do not want to choose an agent.**

**B. My Agent**

Agent’s Name: Street Address:

City, State, Zip Code:

Home Phone: ( ) Work Phone: ( )

Cell Phone: ( )

**C. My Alternate Agent**

***T*C*h*. *is*M*p*y*er*A*so*lt*n*er*w*n*i*a*ll*te*se*A*rv*g*e*en*as*t *your agent if your agent, named above, is unable or unwilling to serve.*** A***Th***lt***i***e***s***rn***p***a***e***t***r***e***so***A***n***g***w***en***il***t***l***’s***se***N***r***a***v***m***e a***e:***s your agent if your agent, named above, is unable or unwilling to serve.*** SAtlrteeertnAatdedAregsesn:t’s Name:

CStirtyee, tSAtadted,reZsisp: ~~Code:~~

HCoitmy,eSPtahtoen, eZ:ip( Code:

~~) Cell Phone: ( )~~

WHoomrkePPhhoonnee:: ( )

Cell Phone: ( )

Work Phone: ( )

\*50000\*

Advan Dir 50000

**Page 1 of 4**

**Page 1 of 4**

**D. Agent’s Authority**

**D. Agent’s Authority.**

**Part I: My Agent (*continued)***

If I cannot make decisions or speak for myself (in other words, after my physician or another authorized provider If I cannot make decisions or speak for myself (in other words, after my physician or another authorized provider finds that I lfainckdshethalatthIclaarcekdehceiasilothn cmaarkeidngecciaspioacnitmy auknidnegr Sceacptaiocnity75u-2nad-e1r04SeocfttihoenA7d5v-a2nac-e10H4eaolfththCearAedDviarenccteivHe eAacltt)h, mCyaraegent has

tDheirepcotwiveer tAo cmt)a,kme aynaygheenatlthhacsatrheedepcoiwsioenr tIocomualdkehaavneymhaedaeltshucharaes,dbeuctisniootnliImcioteudldtoh: ave made such as, but not

limited to:

• Consent to, refuse, or withdraw any health care. This

• Hire and fire health care providers.

mayCinocnlusdeentcatore, rtoefpursoelo, nogr mwyithlidferaswuchanays fhoeoadltahndcare. This may include care to prolong my life such as food and

f luidfslubiydstubbye, tuusbeeo, fuasnetiobfioatinctsi,bCioPtRics(c,aCrdPioRpu(clmarodniaorpyulm•onAasrkyqrueessutisocnitsaatinodng)e, taanndswdiearlsyfsriosm, ahnedalmthecnatraelphreoavlitdhercsa. re,

resuscuictahtiaosn)c, oand udlisailvyesist,haenradpmyeanntadl phesaylcth ocaret,ivseucmh edic• aCtioonnsse.nTt htoisadamutihsosirointyoirstrsaunbsjfeecr ttotoa ahneyaltlhimcaitrse ipnrovider

as copnavrualgsrivaephthFeraopfyPaanrdt IpsoyrcihnoaPcatirvteIImoefditchaitsiodnisr.ective.

ThisHauirtehoarnitdy fiisrseuhbejeacltthtocaanrye lpimroivtsidinerpsa.ragraph F

of Part I or in Part II of this directive.

or health care facility, including a mental health facility,

subject to any limits in paragraphs E or F of Part I.

• Get copies of my medical records.

 Ask questions and get answers from health care pro• vAidsekrfso.r consultations or second opinions.

My ageCntocnasnennotttfooracdemheiaslstihocnaroer atgrainssftemr ytowailhl,eeavletnh icfaarephpyrsoicviaidnehraosrfohuenadltthhactaIrelacfakchieliatlyth, icnacreluddeicnisgioanmmeanktinagl hceapaaltchity.

facility, subject to any limits in paragraphs E or F of Part I.

Get copies of my medical records.

**E.****Ag for myself**.

**ent’s authority when I can speak**

CompleAteskthfiosrseccotniosnulOtaNtiLoYnsIForyoseucwoanndt oypouinriAongse.nt to have authority to access your health care records starting today.

OMtyheargweinset,cyaonunroAt gfeonrtcemhayeaolnthlycaacrceeassgayionusrthmeayltwh rilelc,oervdesnifiyf oaupchayns’ticsipaenakhafosrfyoouunrdsetlhf,aatsIelxapclkaihneeadlitnh SceacretiodnecDisaiboonve.

mMaykaignegnct ahpasacthiteyp. owers below ONLY IF I initial the “yes” option that precedes the statement. I authorize my agent to:

**EM.edOictahl eRrecAourdtshority**

YES Access all my medical records; OR

**Health Care Financial Records**

YES Access all my health care financial, billing

My agent has the powers below only if I initial the “***yes***” option that precedes the statement. I authorize my agent to:

YES Access my medical records for the treatment

and payment records; OR

YES dates oNfO Get copies tof my medical r;eacnodrds at any tiYmEeS, evAecncewsshmeny Ihecaalnthscpaereakfinfoarncmiayl,seblifll.ing and

YYEESS AccesNs mOy sAendsmitiivtemmeetdoicaallicnefonrsmedathioenalwthhicahre facility, suchpayma ehnot srpecitoarld, snfuorrstihnegthreoamtmee, natsdsiastteesd living,

includes anyomreontthalehrefaalcthiltirteyatfmorenlot,npgsy-tcehromlogpilcaaclement other thoaf ~~n convalescen~~ttoo~~r recuperative~~. care.

testing, addiction treatment, treatment for HIV or

**F. Limits**se**/E**xu**x**a**p**lly**an**tr**s**an**io**sm**n**it**o**te**f**d**A**d**u**ise**th**as**o**es**r**.**ity**

YES Other (please specify)

~~I wi~~sYhEtoS liOmtihteor r(pelxepasaensdptehceifyp)o~~wers of my health care~~ agent as follow s: .

.

**~~F. Other Authority Including Limits/Expansion of Authority~~**~~.~~  ~~My agent has the powers and limitations below ONLY IF I initial the “yes” option that precedes the statement. I authorize~~  my agent to:

**G. N**Y**o**E**m**S **in**A**a**d**t**m**io**it**n**m**o**e**f**to**G**a**u**l**a**ic**r**e**d**ns**ia**ed**n**health care facility, such as a hospital, nursing home, assisted living, or other facility

*Even thoug*f*h*or*a*l*p*o*p*n*o*g-*in*te*t*r*i*m*ng*p*a*la*n*ce*a*m*g*ent o*s*t*h*h*o*e*u*r *l*t*d*ha*h*n*el*c*p*on*y*v*o*a*u*le*a*sc*v*e*o*n*id*t o*a*r r*g*e*u*c*a*u*r*p*d*e*i*r*a*a*n*ti*s*v*h*e*i*c*p*a*,*r*a*e.*guardianship may still be necessary. Initia*Y*l*E*th*S*e "*I*Y*w*E*i*S*s*"*h *o*to*p*l*t*i*i*m*on*it *i*o*f*r*y*e*o*x*u*pa*w*n*a*d*n*t*t*h*t*e*h*p*e*o*c*w*o*e*u*r*r*s*t*o*t*f*o*m*a*y*pp*he*o*a*in*lt*t*h *y*c*o*a*u*re*r* a*a*g*g*e*e*n*n*t *t*as*or*fo*,* l*i*l*f*o*y*w*o*s*u*: *r agent is unable or unwilling to serve, your alternate agent, to serve as your guardian, if a guardianship is ever necessary.*

\_

YES NO I, being of sound mind and not acting under duress, fraud, or other undue influence, do hereby

**G. Nomination of G**n**u**om**ar**i**d**na**ia**te**n**my agent, or if my agent is unable or unwilling to serve, I hereby nominate my

Even though appointinagltearnnaagteenatgsehnotu, ltdo hseelrpvyeoaus amvoyidguaagrudaiardniainnsthhiep,eavegnutarthdiaatn, sahftipermthaey dstailtleboef ntehcisesisnasrtyr.uImnietniatl, tIhe “YES” option if you want the court to appoint your agent or, if your agent is unable or unwilling to serve, your alternate agent, to serve as your guardian, if a guardianship is ever necessary.

YES

NO I, being of sound mind and not acting under duress, fraud, or other undue inf luence, do hereby

**H. Consent to P**no**a**m**r**i**t**n**ic**at**i**e**p**m**at**y**e**a**i**g**n**en**M**t, o**e**r**d**i**i**f**c**m**a**y**l R**ag**e**e**s**n**e**t **a**is**r**u**c**n**h**able or unwilling to serve, I hereby nominate my alternate

YES NOagenI ta, utothsoerrvizeeasmmyyaggueanrdt itaoncinonthseenevt etnot mthayt,paafrtetirctihpeadtiaotenoifnthmiseidnisctarul mreesnet,aIrcbhecoormceliincicaaplactritiaatlesd,.even

if I may not benefit from the results.

**H. Consent to Participate in Medical Research**

**~~I.~~** Y**O**E**r**S**g~~an D~~**N**o**O**na**I**ti**a**o**u**n**thorize my agent to consent to my participation.

**I.** YES NO If I have not otherwise agreed to organ donation, my agent may consent to the donation of my

**Organ Donation**

organs for the purpose of organ transplantation.

YES



NO If I have not otherwise agreed to organ donation, my agent may consent to the donation of my organs

for the purpose of organ transplantation.

**Part II: My Health Care Wishes (*Living Will*)**

I want my health care providers to follow the instructions I give them when I am being treated, even if my instructions conflict with these or other advance directives. My health care providers should always provide health care to keep me as comfortable and functional as possible.

***Choose only one*** *of the following options, numbered Option 1 through Option 4, by placing your initials before the numbered statement. Do not initial more than one option. If you do not wish to document end-of-life wishes, initial Option 4. You may choose to draw a line through the options that you are not choosing.*

|  |  |  |  |
| --- | --- | --- | --- |
| **Option 1** | | | |
| Initial | **I choose to let my agent decide.** I have chosen my agent carefully. I have talked with my agent about my health care wishes. I trust my agent to make the health care decisions for me that I would make under the circumstances. | | |
| Additional comments: | | | |
|  | | | |
| **Option 2** | | | |
| Initial | **I choose to prolong life.** Regardless of my condition or prognosis, I want my health care team to try to prolong my life as long as possible within the limits of generally accepted health care standards. | | |
| Additional comments: | | | |
|  | | | |
| **Option 3** | | | |
| Initial | | **I choose not to receive care for the purpose of prolonging life,** including food and fluids by tube, antibiotics, CPR, or dialysis being used to prolong my life. I always want comfort care and routine medical care that will keep me as comfortable and functional as possible, even if that care may prolong my life. | |
| ***If you choose this option, you must also choose either (a) or (b), below*** | | | |
| Initial | | (a) I put no limit on the ability of my health care provider or agent to withhold or withdraw life- sustaining care. | |
| Initial | | (b) My health care provider should withhold or withdraw life-sustaining care if ***at least one*** of the initialed conditions is met: | |
| ***If you selected (a), above, do not***  ***choose any options under (b).*** | |  | I have a progressive illness that will cause death |
|  | I am close to death and am unlikely to recover |
|  | I cannot communicate and it is unlikely that my condition will improve |
|  | I do not recognize my friends or family and it is unlikely that my condition will improve |
|  | I am in a persistent vegetative state |
| Additional comments: | | | |

|  |  |
| --- | --- |
| **Option 4** | |
| Initial | I do not wish to express preferences about health care wishes in this directive. |
| Additional comments | |

**Part II: My Health Care Wishes (*continued*) Part II: My Health Care Wishes (*continued*)**

*Additional instructions about your health care wishes: Additional instructions about your health care wishes:*

*\_Additional instructions about your health care wishes:*

*\_*

*\_*

*If you do not want emergency medical service providers to provide CPR or other life sustaining measures, you must work with a you do not want emergency medical service providers to provide CPR or other life sustaining measures, you must work with a pIfpyhoyusidcoianootrwAaPnRt eNmteorcgoemncpylemteedaincaolrds ervtihcaetprreoflveicdtesrsyotourpwroisvhidees ConPRa foorrmothaeprplriofevesdusbtayitnhiengUmtaehaDsuerpeas,rtymoeunmt oufstHweoarltkhw*. *ith a*

*If*

*hysician or APRN to complete an order that reflects your wishes on a form approved by the Utah Department of Health*.

*physician or APRN to complete an order that reflects your wishes on a form approved by the Utah Department of Health*.

**Part III: Revoking or Changing a Directive Part III: Revoking or Changing a Directive Part III: Revoking or Changing a Directive**

I may revoke or change this directive by:

I

may revoke or change this directive by:

I may reWvorkiteinogr “cvhoanidg”e atchrios sdsirtehcetifvoermby, :burning, tearing, or otherwise destroying or defacing this document or directing another

 Writing “void” across the form, burning, tearing, or otherwise destroying or defacing this document or directing another

 Wpreirtsinogn “tovodiod”thaecrsoasmsethoenfmorymb, ebhuarlnf;ing, tearing, or otherwise destroying or defacing this document or directing another

person to do the same on my behalf;

 pSerisgonnintgo adowtrhitetesnamreevocnamtioynboefhtahlfe; directive, or directing another person to sign a revocation on my behalf;

 Signing a written revocation of the directive, or directing another person to sign a revocation on my behalf;

 SSigtantiinnggathwartiIttwenisrhevto craetviokeotfhtehedidreircetcivtievein, othr ediprreecstei ngceanoof tahewritpneerssonwthoos: iigsn1a8 ryeevaorcsaotifoangoenormoyldbeerh; awlfi;ll not be

 Stating that I wish to revoke the directive in the presence of a witness who: is 18 years of age or older; will not be

 Stating that I wish to revoke the d rective in th prese ce of a witness who: is 18 years of age or older; will not be

appointed as my agent in a substitute directive; will not become a default surrogate if the directive is revoked; and signs appointed as my agent in a substitute directive; will not become a default surrogate if the directive is revoked; and signs

apanp

idnatetedsaas wmryittaegnendtoicnuma seunbt sctoitnuftiermdiirnegctmivye;swtaitlelmneont tb; eocrome a default surrogate if the directive is revoked; and signs

and dates a written document confirming my statement; or

 anSdigdnaintegs a nwerwittdeinredcoticvuem. (e***I***n***f***t ***y***c***o***o***u***nf***s***i***i***r***g***m***n***in***m***g***o***m***re***y***th***st***a***a***n***te***o***m***n***e***e***nt***A***; ***d***o***v***r***ance Health Care Directive, the most recent one applies.)***

 Signing a new directive. (***If you sign more than one Advance Health Care Directive, the most recent one applies.)***

 Signing a new directive. (***If you sign more than one Advance Health Care Directive, the most recent one applies.)***

**Part IV: Making My Directive Legal art IV: Making My Directive Legal Part IV: Making My Directive Legal**

**P**

I sign this directive voluntarily. I understand the choices I have made and declare that I am emotionally and mentally competent sign this directive voluntarily. I understand the choices I have made and declare that I am emotionally and mentally competent

I

toI tsoigmnatkheistdhirsedcitrivecetivvoel.unMtayrislyig. nIautunrdeerosntatnhdisthfoercmhoreicveoskIesh aney mlivaidnegawndilldoerclpaorewtehraot fI aatmtorenmeyotfiornmallnyaamnidngmaenhteaallthccoamrepaegteenntt

make this directive. My signature on this form revokes any living will or power of attorney form naming a health care agent

thtothmatakI ehathvies cdoimrepctlievted. iMn ythseigpnaasttu. re on this form revokes any living will or power of attorney form naming a health care agent

at I have completed in the past.

that I have completed in the past.

\_ Date

D

ate

\_ Signature

S

ignature

Date Signature

\_ City, County, and State of Residence

C

ity, County, and State of Residence

City, County, and State of Residence

I have witnessed the signing of this directive, I am 18 years of age or older, and I am not:

I

have witnessed the signing of this directive, I am 18 years of age or older, and I am not:

I 1h.aveRweliatnt edssteodtthheedseigclnairnagntobf ythbislodoidreocrtimvea,rIriaamge1; 8 years of age or older, and I am not:

1. Related to the declarant by blood or marriage;

12. .

REelnattietldedtotothaendyepcolarrtaionnt boyf tbhleooddecolrarmanatr'rsiaegstea;te according to the laws of intestate succession of any state or jurisdiction or

2. Entitled to any portion of the declarant's estate according to the laws of intestate succession of any state or jurisdiction or

nder any will or codicil of the declarant,

2.

3.3.

uEunntidtleerdatnoyawnyillpoorrtciodiocifltohfe tdheecdlaercalnatr'asnets, tate according to the laws of intestate succession of any state or jurisdiction or uAndberenaenfyicwiairlyl oorfcaoldiifceilinosfutrhaencdeecploalriacnyt,, trust, qualified plan, pay on death account, or transfer or death deed that is held,

A beneficiary of a life insurance policy, trust, qualified plan, pay on death account, or transfer or death deed that is held,

3. Aobwenneedf,icmiaardyeo, foar elisfteabinlissuhreadncbey,porliocyn,bteruhsatl,fqoufa, ltihfieedepcllaanra, npta;y on death account, or transfer or death deed that is held,

owned, made, or established by, or on behalf of, the declarant;

4.4.

45. .

oEwnnteidtl,edmtaodeb,eonrefeisttfaibnlainshceiadllbyyu, poornonthbeedheaalfthoof,ftthheeddeeccllaarraanntt;; Entitled to benefit financially upon the death of the declarant;

EEnntitilteldedtotobeanreigfihttftion,anocr iianltleyreusptoinn,threadl eoarthpeorfsothnealdpercolaprearntyt; upon the death of the declarant;

5. Entitled to a right to, or interest in, real or personal property upon the death of the declarant;

56. .

EDntiirtelecdtlytofianaringchitaltloy, roersipnotenrseibstleinf,orretahleodrepcelrasroanat'ls pmroepdeicratyl cuaproen; the death of the declarant;

6. Directly financially responsible for the declarant's medical care;

67. .

DAirehcetalylthfincarneciparlolyvirdeesrpwonhsoibilsepfroorvtihdeindgeclaarreantot'sthme eddeicclaalracnarteo;r an administrator at a health care facility in which the

7. A health care provider who is providing care to the declarant or an administrator at a health care facility in which the

7. Adhecelaalrthanctairserpercoevividinegr wcahroe;isorproviding care to the declarant or an administrator at a health care facility in which the

declarant is receiving care; or

8.8.

deTchlearaapnpt oisinrteecdeiavgienngt coarrael;toernate agent. The appointed agent or alternate agent.

8. The appointed agent or alternate agent.

\_ \_

Signature of Witness Printed Name of Witness Signature of Witness Printed Name of Witness Signature of Witness Printed Name of Witness

\_

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Street Address City State Zip Street Address City State Zip Street Address City State Zip

***If the witness is signing to confirm an oral directive, describe below the circumstances under which the directive was made. the witness is signing to confirm an oral directive, describe below the circumstances under which the directive was made.***

***If***

***If the witness is signing to confirm an oral directive, describe below the circumstances under which the directive was made.***

***\_***