EASTBROOK FAMILY HEALTH CENTER
ADVANCE DIRECTIVE (LIVING WILL) DECLARATION

I, _____, being of sound mind, willfully and voluntarily make this declaration to be followed if I become incompetent. This declaration reflects my firm and settled commitme to refuse life sustaining treatment under the circumstances indicated below.

I direct my attending physician to withhold or withdraw life-sustaining treatment that serves only to prolong the process of dying if I should be in a terminal condition or in a state of permanent unconsciousness.

I direct that treatment be limited to measures to keep me comfortable and to relieve pain, including any pair that might occur by withholding or withdrawing life-sustaining treatment.

In addition, if I am in the condition described above, I feel especially strongly about the following forms of treatment.

I DO	I DO NOT	
_____	_____	want cardiac resuscitation.
_____	_____	want mechanical respiration.
_____	_____	want tube feeding.
_____	_____	want other artificial or invasive form of nutrition (food).
_____	_____	want other artificial or invasive form of hydration (water).
_____	_____	want blood or blood products.
_____	_____	want any form of surgery.
_____	_____	want any invasive diagnostic tests.
_____	_____	want kidney dialysis.
_____	_____	want antibiotics.
_____	_____	other:

I realize that I do not specifically indicate my preference regarding any of the forms of treatment listed above, I may receive that form of treatment.

HEALTH CARE POWER OF ATTORNEY

I, _____, of _____ County, Pennsylvania, appoint the person named below to be my Health Care Agent to make health and personal care decisions for me whenever I lack the ability to understand, make or communicate a choice regarding a health care decision as verified by my attending physician or whenever I personally inform my attending physician.

My agent may not delegate the authority to make decisions.

I appoint the following Health Care Power of Attorney: *You may not appoint your doctor or other health care provider as your Health Care Power Of Attorney unless related to by blood, marriage or adoption.*

HEALTH CARE POWER OF ATTORNEY:_____

(Name and Relationship)

ADDRESS:_____ HOME PHONE NUMBER_____

_____ WORK PHONE NUMBER:_____

EMAIL:_____ CELL NUMBER:_____

EB ADVANCE DIRECTIVE (LIVING WILL) DECLARATION

If my Health Care Power Of Attorney is not reasonably available or if my Health Care Power Of Attorney is my spouse and an action for divorce is filed by either of us after the date of this document, I appoint the person persons named below in the order named. (It is helpful, but not required, to name alternative Health Care Power Of Attorney).

1st ALTERNATE: Name and Relationship:_____
Address:_____
City, State, Zip:_____
Home Phone Number:_____ Cell Number:_____
Work Phone Number:_____ Email:_____

2nd ALTERNATE: Name and Relationship:_____
Address:_____
City, State, Zip:_____
Home Phone Number:_____ Cell Number:_____
Work Phone Number:_____ Email:_____

Separate HIPAA Authorization Effective Immediately:
Effective immediately and continuously until my death or revocation by a writing signed by me or someone authorized to make health care treatment decisions for me, I authorize all health care providers or other covered entities to disclose to my Health Care Power Of Attorney, upon my Attorney's request, any information, oral or written, regarding my physical or mental health, including, but not limited to, medical and hospital records and what is otherwise private, privileged, protected or personal health information, such as health information as defined and described in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the regulations issued under HIPAA and any other state or local laws and rules. Information disclosed by a health care provider or other covered entity may be redisclosed and may no longer be subject to these privacy rules.

Legal Protection
Pennsylvania law protects my Health Care Power Of Attorney and health care providers from any legal liability for their good faith actions in following my wishes as expressed in this form or in complying with my Health Care Power Of Attorney's direction. On behalf of myself, my executors and heirs, I further hold my Health Care Power Of Attorney and my health care providers harmless and indemnify them against any claim for their good faith actions in recognizing my Health Care Power Of Attorney's authority or in following my treatment instructions.

EB ADVANCE DIRECTICE (LIVING WILL) DECLARATION

Organ Donation (Initial one option only.)

_____ **I do consent** to donate my organs and tissues at the time of my death for the purpose of transplant, medical study or education. (Insert any limitations you desire on donation of specific organs or tissues or uses for donation of organs and tissues.)

OR

_____ **I do not consent** to donate my organs or tissues at the time of my death.

SIGNATURE:

Having carefully read this document, I have signed it this _____ day of _____, 20_____, revoking all previous health care powers of attorney and health care treatment instructions.

Witnesses

_____ _____

(Signature)

_____ _____

(Printed Name)

_____

(Address)

_____

(City, State, Zip)

_____

(Date of Birth)

** *Two witnesses at least 18 years of age are required by Pennsylvania law and should witness your signature in each other's presence. A person who signs this document on behalf of, and at the direction of, a principal may not be a witness. (It is preferable if the witnesses are not your heirs, nor your creditors, nor employed by any of your health care providers.)*