LIVING WILL DECLARATION
and
DESIGNATION OF HEALTH CARE SURROGATE AND AGENT

I, __________________________, being of sound mind, willfully and voluntarily provide as follows:

A. LIVING WILL DECLARATION

I make this declaration to be followed if I become incompetent. This declaration reflects my firm and settled commitment 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 my 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 pain that might occur by withholding or withdrawing life-sustaining treatment.

In addition, if I am in the condition described above, I direct that the forms of treatment marked below be withheld or withdrawn:

_____ cardiac resuscitation
_____ mechanical respiration
_____ tube feeding or any other artificial or invasive form of nutrition (food) or hydration (water)
_____ blood or blood products
_____ any form of surgery or invasive diagnostic tests
_____ kidney dialysis
_____ antibiotics

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

B. HEALTH CARE SURROGATE AND AGENT DESIGNATION

I hereby designate ____________________________ whose address is ____:

1. As my surrogate to make medical decisions for me if I should be incompetent and either in a terminal condition or in a state of permanent unconsciousness.

2. As my agent to do the following:

(a) To authorize my admission to a medical, nursing, residential or similar facility and to enter into agreements for my care.

(b) To authorize medical and surgical procedures.

(c) To authorize an anatomical gift of all or any part of my body.

(d) To request and receive from any health care provider all of my individually identifiable health information and medical records relating to my physical and mental condition and to my diagnosis, prognosis, care and treatment. This authority given by me to my agent shall be considered a consent to the release of such information under all applicable laws and shall include (but not be limited to) the express grant of authority to personal representatives as provided by Regulation Section 164.502(g) of Title 45 of the Code of Federal Regulations and the medical information privacy law and regulations generally referred to as HIPAA (or any successor thereto). This authority given to my agent has no expiration date and shall expire only in the event that I revoke the authority in a writing delivered to my health care provider. The term "health care provider" shall include (but not be limited to) 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. Each reference to applicable laws shall include all laws now or in the future, any rules and regulations promulgated thereunder from time to time (and any amendments thereto).

This document shall not be affected by my subsequent disability or incapacity, or lapse of time.

Executed this ____ day of ____________, 2005.

____
Declarant

The declarant, knowingly and voluntarily signed this writing in our presence.

______________________________	______________________________
Witness's signature	Witness's address
______________________________	______________________________
Witness's signature	Witness's address

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