

**LIVING WILL
TO MY FAMILY AND PHYSICIAN:**

If I, _____, of _____, _____ County, Pennsylvania become incompetent and am unable to direct my own health care, this statement of my wishes should be respected and followed. These instructions shall prevail even if they conflict with the desires of my relatives, hospital policies, or principles of those providing my care.

End-of-Life Decisions

I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

Relief from Pain

I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death.

Organ Donation Instructions

Upon my death, I donate any needed organs, tissues, or other body parts for any purpose allowed under applicable law.

Primary Physician

I designate _____, _____ as my primary physician.
(Name) (degree)

Contact information:

Health Care Agent

I, _____, of _____, _____ County, Pennsylvania, appoint the person named below to be my health care agent to make health and personal care decisions for me. 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 agent, upon my agent'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 (Public Law 104-191, 110 Stat. 1936), the regulations promulgated there under 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 the privacy rules provided by 45 C.F.R. Pt. 164.

This document will take effect when and only when I lack the ability to understand, make or communicate a choice regarding a health or personal care decision as verified by my attending physician.

My health care agent may not delegate the authority to make decisions.

My health care agent has all of the following powers, subject to any health care treatment instructions that I give in this document (cross out and initial any powers you do not want to give your health care agent):

1. To authorize, withhold or withdraw medical care and surgical procedures.
2. To authorize my admission to or discharge from a medical, nursing, residential or similar facility and to make agreements for my care and health insurance for my care, including hospice and/or palliative care.
3. To hire and fire medical, social service and other support personnel responsible for my care.
4. To take any legal action necessary to do what I have directed.
5. To request that a physician responsible for my care issue a do-not-resuscitate (DNR) order, including an out-of-hospital DNR order, and sign any required documents and consents.

APPOINTMENT OF HEALTH CARE AGENT

I appoint the following health care agent:

Health Care Agent: _____
(Name and relationship)

Address: _____

Telephone Number: Home _____ Work _____

E-mail: _____

IF YOU DO NOT NAME A HEALTH CARE AGENT, HEALTH CARE PROVIDERS WILL ASK YOUR FAMILY OR AN ADULT WHO KNOWS YOUR PREFERENCES AND VALUES FOR HELP IN DETERMINING YOUR WISHES FOR TREATMENT.

NOTE THAT YOU MAY NOT APPOINT YOUR DOCTOR OR OTHER HEALTH CARE PROVIDER AS YOUR HEALTH CARE AGENT UNLESS RELATED TO YOU BY BLOOD, MARRIAGE OR ADOPTION.

If my health care agent is not readily available or if my health care agent is my spouse and an action for divorce is filed by either of us after the date of this document, I appoint the person or persons named below in the order named. (It is helpful, but not required, to name alternative health care agents.)

First Alternative Health Care Agent: _____
(Name and relationship)

Address: _____

Telephone Number: Home _____ Cell _____

E-mail: _____

Second Alternative Health Care Agent: _____

(Name and relationship)

Address: _____

Telephone Number: Home _____ Cell _____

E-mail: _____

Governing Law

I intend this document to be my Living Will under Pennsylvania law. However, if any of my health care instructions go beyond what Pennsylvania authorizes, I request that those instructions be respected and followed in keeping with my right to direct my own health care as guaranteed by the U.S. constitution

Definitions

For purposes of this document:

Health care means any care, treatment, service, or procedure to maintain, diagnose, treat or provide for physical or mental health, custodial or personal care, including any medication program, therapeutical or surgical procedure, and life-sustaining treatment.

Permanently unconscious means a medical condition that has been diagnosed in accordance with currently accepted medical standards and with reasonable medical certainty as total and irreversible loss of consciousness and capacity for interaction with the environment. The term includes, without limitation, an irreversible vegetative state or irreversible coma.

End-stage medical condition means an incurable and irreversible medical condition in an advanced state caused by injury, disease, or illness that will, in the opinion of the attending physician to a reasonable degree of medical certainty, result in death, despite the introduction or continuation of medical treatment. Except as specifically set forth in an advance health care directive, the term is not intended to preclude treatment of a disease, illness, or physical, mental, cognitive, or intellectual condition, even if incurable and irreversible and regardless of severity, if both of the following apply:

- (1) the patient would benefit from medical treatment, including palliative care, and
- (2) such treatment would not merely prolong the process of dying.

Life-sustaining treatment means any medical procedure or intervention that, when administered to a patient who has an end-stage medical condition or is permanently unconscious, will serve only to prolong the process of dying or maintain the individual in a state of permanent unconsciousness. Life-sustaining treatment does not include artificially administered nutrition and hydration.

Artificially administered nutrition and hydration means a mix of nutrients and fluids administered by gastric tube or intravenously or any other artificial or invasive means, depending on the patient's condition.

Effect of Copy

A copy of this document has the same effect as the original.

Severability

If a court finds any of the specific provisions in this document to be invalid, that shall not affect other provisions that can be given effect without the invalid provision.

Legal Protection

Pennsylvania law protects my health care agent 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 agent's direction. On behalf of myself, my executors, and my heirs, I further hold my health care agent and my health care providers harmless and indemnify them against any claim for their good faith actions in recognizing my health care agent's authority or in following my treatment decisions.

Signature

Having carefully read this document, I have signed it this _____ day of _____, _____, revoking all previous living wills.

Signature: _____

Address: _____

Witnesses

The declarant or the person on behalf of and at the direction of the declarant knowingly and voluntarily signed this writing by signature or mark in my presence. I am at least 18 years old, and am not the person who signed this document on behalf of and at the direction of the declarant.

I am not related to the declarant by blood or marriage, nor would I be entitled to any portion of the declarant's estate upon his decease, nor am I an attending physician of the declarant, nor an employee of the attending physician, nor an employee of a health care facility in which the declarant is a patient, nor a patient in a health care facility in which the declarant is a patient, nor am I a person who has any claim against any portion of the estate of the declarant upon his death.

Witness's Signature _____

Witness's Signature _____