



FindLaw[®]

Legal Forms & Services

FirstName LastName

SOUTH CAROLINA
HEALTH CARE DIRECTIVE
& LIVING WILL

DISCLAIMER:

You use FindLaw's self-help services, forms, and information under your own direction and at your own risk. FindLaw and its affiliates are not a law firm or a substitute for an attorney or law firm and do not represent you or provide legal advice on any matter. The use of FindLaw's self-help services does not create any attorney-client relationship. Communication between you and FindLaw is not protected by attorney-client privilege or as a work product. If you need legal advice or representation, please seek the assistance of an experienced attorney.

The answers you provide in the questionnaire are incorporated in this document at your direction. The form was developed by attorneys based on the laws of your state. You are responsible for finalizing the document and having it reviewed by an attorney.

Finalizing a Health Care Directive & Living Will in South Carolina

After printing your document, you will need to finalize it. Below are the steps:

1. Print out your document
2. Review, initial, sign, and date in front of two witnesses and a notary
3. Have witnesses sign and date
4. Have notary sign and date
5. Keep document in a safe place

Notice: Some state laws require the principal to initial next to the instructions they have provided in order for that instruction to be effective. Review the state laws applicable to health care directives and living wills, review the document carefully, and initial where required by law.

Some state laws prohibit the designation of certain people as a health care agent. To avoid that result, you should review your state laws applicable to who can and cannot be a health care agent.

Some state laws prohibit certain people from being witnesses to a health care directive and living will. Review your state's laws on witness requirements for health care directives and living wills.

HEALTH CARE DIRECTIVE & LIVING WILL

FOR

FirstName LastName

This document includes the following:

Health care power of attorney designating an agent to make my health care decisions based on these instructions if I am unable to speak or make them myself. If my wishes are unknown, my health care agent should act in my best interest.

INFORMATION ABOUT THIS DOCUMENT

THIS IS AN IMPORTANT LEGAL DOCUMENT. BEFORE SIGNING THIS DOCUMENT, YOU SHOULD KNOW THESE IMPORTANT FACTS:

1. THIS DOCUMENT GIVES THE PERSON YOU NAME AS YOUR AGENT THE POWER TO MAKE HEALTH CARE DECISIONS FOR YOU IF YOU CANNOT MAKE THE DECISION FOR YOURSELF. THIS POWER INCLUDES THE POWER TO MAKE DECISIONS ABOUT LIFE-SUSTAINING TREATMENT. UNLESS YOU STATE OTHERWISE, YOUR AGENT WILL HAVE THE SAME AUTHORITY TO MAKE DECISIONS ABOUT YOUR HEALTH CARE AS YOU WOULD HAVE.
2. THIS POWER IS SUBJECT TO ANY LIMITATIONS OR STATEMENTS OF YOUR DESIRES THAT YOU INCLUDE IN THIS DOCUMENT. YOU MAY STATE IN THIS DOCUMENT ANY TREATMENT YOU DO NOT DESIRE OR TREATMENT YOU WANT TO BE SURE YOU RECEIVE. YOUR AGENT WILL BE OBLIGATED TO FOLLOW YOUR INSTRUCTIONS WHEN MAKING DECISIONS ON YOUR BEHALF. YOU MAY ATTACH ADDITIONAL PAGES IF YOU NEED MORE SPACE TO COMPLETE THE STATEMENT.
3. AFTER YOU HAVE SIGNED THIS DOCUMENT, YOU HAVE THE RIGHT TO MAKE HEALTH CARE DECISIONS FOR YOURSELF IF YOU ARE MENTALLY COMPETENT TO DO SO. AFTER YOU HAVE SIGNED THIS DOCUMENT, NO TREATMENT MAY BE GIVEN TO YOU OR STOPPED OVER YOUR OBJECTION IF YOU ARE MENTALLY COMPETENT TO MAKE THAT DECISION.
4. YOU HAVE THE RIGHT TO REVOKE THIS DOCUMENT, AND TERMINATE YOUR AGENT'S AUTHORITY, BY INFORMING EITHER YOUR AGENT OR YOUR HEALTH CARE PROVIDER ORALLY OR IN WRITING.
5. IF THERE IS ANYTHING IN THIS DOCUMENT THAT YOU DO NOT UNDERSTAND, YOU SHOULD ASK A SOCIAL WORKER, LAWYER, OR OTHER PERSON TO EXPLAIN IT TO YOU.

6. THIS POWER OF ATTORNEY WILL NOT BE VALID UNLESS TWO PERSONS SIGN AS WITNESSES. EACH OF THESE PERSONS MUST EITHER WITNESS YOUR SIGNING OF THE POWER OF ATTORNEY OR WITNESS YOUR ACKNOWLEDGMENT THAT THE SIGNATURE ON THE POWER OF ATTORNEY IS YOURS. THE FOLLOWING PERSONS MAY NOT ACT AS WITNESSES:

A. YOUR SPOUSE, YOUR CHILDREN, GRANDCHILDREN, AND OTHER LINEAL DESCENDANTS; YOUR PARENTS, GRANDPARENTS, AND OTHER LINEAL ANCESTORS; YOUR SIBLINGS AND THEIR LINEAL DESCENDANTS; OR A SPOUSE OF ANY OF THESE PERSONS.

B. A PERSON WHO IS DIRECTLY FINANCIALLY RESPONSIBLE FOR YOUR MEDICAL CARE.

C. A PERSON WHO IS NAMED IN YOUR WILL, OR, IF YOU HAVE NO WILL, WHO WOULD INHERIT YOUR PROPERTY BY INTESTATE SUCCESSION.

D. BENEFICIARY OF A LIFE INSURANCE POLICY ON YOUR LIFE.

E. THE PERSONS NAMED IN THE HEALTH CARE POWER OF ATTORNEY AS YOUR AGENT OR SUCCESSOR AGENT.

F. YOUR PHYSICIAN OR AN EMPLOYEE OF YOUR PHYSICIAN.

G. A PERSON WHO WOULD HAVE A CLAIM AGAINST ANY PORTION OF YOUR ESTATE (PERSONS TO WHOM YOU OWE MONEY).

IF YOU ARE A PATIENT IN A HEALTH FACILITY, NO MORE THAN ONE WITNESS MAY BE AN EMPLOYEE OF THAT FACILITY.

7. YOUR AGENT MUST BE A PERSON WHO IS 18 YEARS OF AGE OR OLDER AND OF SOUND MIND. IT MAY NOT BE YOUR DOCTOR OR ANY OTHER HEALTH CARE PROVIDER THAT IS NOW PROVIDING YOU WITH TREATMENT; OR AN EMPLOYEE OF YOUR DOCTOR OR PROVIDER; OR A SPOUSE OF THE DOCTOR, PROVIDER, OR EMPLOYEE; UNLESS THE PERSON IS A RELATIVE OF YOURS.

8. YOU SHOULD INFORM THE PERSON THAT YOU WANT HIM OR HER TO BE YOUR HEALTH CARE AGENT. YOU SHOULD DISCUSS THIS DOCUMENT WITH YOUR AGENT AND YOUR PHYSICIAN AND GIVE EACH A SIGNED COPY. IF YOU ARE IN A HEALTH CARE FACILITY OR A NURSING CARE FACILITY, A COPY OF THIS DOCUMENT SHOULD BE INCLUDED IN YOUR MEDICAL RECORD.

HEALTH CARE POWER OF ATTORNEY

1. DESIGNATION OF HEALTH CARE AGENT

I, FirstName LastName, hereby appoint:

Name: FirstName LastName

Relationship: Spouse

Address: 111 Street Address

City, South Carolina 12345

Phone: 555-555-5555

Email: name@email.com

as my agent to make health care decisions for me as authorized in this document.

Successor Agent: If an agent named by me dies, becomes legally disabled, resigns, refuses to act, becomes unavailable, or if an agent who is my spouse is divorced or separated from me, I name the following as successors to my agent, each to act alone and successively, in the order named:

A. First Alternate Agent:

Name: FirstName LastName

Relationship: Son

Address: 222 Street Address

City, South Carolina 12345

Phone: 555-555-5555

Email: name@email.com

Unavailability of Agent(s): If at any relevant time the agent or successor agents named here are unable or unwilling to make decisions concerning my health care, and those decisions are to be made by a guardian, by the Probate Court, or by a surrogate pursuant to the Adult Health Care Consent Act, it is my intention that the guardian, Probate Court, or surrogate make those decisions in accordance with my directions as stated in this document.

2. EFFECTIVE DATE AND DURABILITY

This document is effective upon and only during any period of my mental incompetence.

3. HIPAA AUTHORIZATION

When considering or making health care decisions for the principal, all individually identifiable health information and medical records may be released without restriction to the principal's health care agent and/or alternate health care agent including, but not limited to:

- Diagnostic, treatment, other health care, and related insurance and financial records and information associated with any past, present, or future physical or mental health condition including, but not limited to, diagnosis or treatment of HIV/AIDS, sexually transmitted disease(s), mental illness, and/or drug or alcohol abuse
- Any written opinion relating to the principal's health that such health care agent and/or alternate health care agent may have requested. Without limiting the generality of the foregoing, this release authority applies to all health information and medical records governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. 1320d and 45 C.F.R. 160-164

4. AGENT'S POWERS

I grant to my agent full authority to make decisions for me regarding my health care. In exercising this authority, my agent shall follow my desires as stated in this document or otherwise expressed by me or known to my agent. In making any decision, my agent shall attempt to discuss the proposed decision with me to determine my desires if I am able to communicate in any way. If my agent cannot determine the choice I would want made, then my agent shall make a choice for me based upon what my agent believes to be in my best interests. My agent's authority to interpret my desires is intended to be as broad as possible, except for any limitations I may state below.

Accordingly, unless specifically limited by the provisions specified below, my agent is authorized as follows:

A. To consent, refuse, or withdraw consent to any and all types of medical care, treatment, surgical procedures, diagnostic procedures, medication, and the use of mechanical or other procedures that affect any bodily function, including, but not limited to, artificial respiration, nutritional support and hydration, and cardiopulmonary resuscitation.

B. To authorize, or refuse to authorize, any medication or procedure intended to relieve pain, even though that use may lead to physical damage, addiction, or hasten the moment of, but not intentionally cause, my death.

C. To authorize my admission to or discharge, even against medical advice, from a hospital, nursing care facility, or similar facility or service.

D. To take another action necessary to making, documenting, and assuring implementation of decisions concerning my health care, including, but not limited to, granting a waiver or release from liability required by a hospital, physician, nursing care provider, or other health care provider;

signing any documents relating to refusals of treatment or the leaving of a facility against medical advice, and pursuing any legal action in my name, and at the expense of my estate to force compliance with my wishes as determined by my agent, or to seek actual or punitive damages for the failure to comply.

E. The powers granted above do not include the following powers or are subject to the following rules or limitations: I do not wish to limit the authority of my health care agent at this time.

5. ORGAN DONATION (INITIAL ONLY ONE)

 My agent MAY consent to the donation of all or any of my tissue or organs for purposes of transplantation.

My agent MAY NOT consent to the donation of all or any of my tissue or organs for purposes of transplantation.

6. EFFECT ON DECLARATION OF A DESIRE FOR A NATURAL DEATH (LIVING WILL)

I understand that if I have a valid Declaration of a Desire for a Natural Death, the instructions contained in the Declaration will be given effect in any situation to which they are applicable. My agent will have authority to make decisions concerning my health care only in situations to which the Declaration does not apply.

7. STATEMENT OF DESIRES CONCERNING LIFE-SUSTAINING TREATMENT

With respect to any Life-Sustaining Treatment, I direct the following:

(INITIAL ONLY ONE OF THE FOLLOWING 3 PARAGRAPHS)

A. GRANT OF DISCRETION TO AGENT. I do not want my life to be prolonged nor do I want life-sustaining treatment to be provided or continued if my agent believes the burdens of the treatment outweigh the expected benefits. I want my agent to consider the relief of suffering, my personal beliefs, the expense involved and the quality as well as the possible extension of my life in making decisions concerning life-sustaining treatment.

 B. DIRECTIVE TO WITHHOLD OR WITHDRAW TREATMENT. I do not want my life to be prolonged and I do not want life-sustaining treatment:

1. If I have a condition that is incurable or irreversible and, without the administration of life-sustaining procedures, expected to result in death within a relatively short period of time; or

2. If I am in a state of permanent unconsciousness.

C. DIRECTIVE FOR MAXIMUM TREATMENT. I want my life to be prolonged to the greatest extent possible, within the standards of accepted medical practice, without regard to my condition, the chances I have for recovery, or the cost of the procedures.

8. STATEMENT OF DESIRES REGARDING TUBE FEEDING

With respect to nutrition and hydration provided by means of a nasogastric tube or tube into the stomach, intestines, or veins, I wish to make clear that in situations where life-sustaining treatment is being withheld or withdrawn pursuant to Paragraph 7:

(INITIAL ONLY ONE OF THE FOLLOWING 3 PARAGRAPHS)

A. GRANT OF DISCRETION TO AGENT. I do not want my life to be prolonged by tube feeding if my agent believes the burdens of tube feeding outweigh the expected benefits. I want my agent to consider the relief of suffering, my personal beliefs, the expense involved, and the quality as well as the possible extension of my life in making this decision.

 B. DIRECTIVE TO WITHHOLD OR WITHDRAW TUBE FEEDING. I do not want my life prolonged by tube feeding.

C. DIRECTIVE FOR PROVISION OF TUBE FEEDING. I want tube feeding to be provided within the standards of accepted medical practice, without regard to my condition, the chances I have for recovery, or the cost of the procedure, and without regard to whether other forms of life-sustaining treatment are being withheld or withdrawn.

IF YOU DO NOT INITIAL ANY OF THE STATEMENTS IN PARAGRAPH 8, YOUR AGENT WILL NOT HAVE AUTHORITY TO DIRECT THAT NUTRITION AND HYDRATION NECESSARY FOR COMFORT CARE OR ALLEVIATION OF PAIN BE WITHDRAWN.

9. ADMINISTRATIVE PROVISIONS

A. I revoke any prior Health Care Power of Attorney and any provisions relating to health care of any other prior power of attorney.

B. This power of attorney is intended to be valid in any jurisdiction in which it is presented.

SIGNATURES

This document must be signed and dated by me. It also must be verified by two witnesses AND a notary public.

BY SIGNING HERE I, FirstName LastName, INDICATE THAT I UNDERSTAND THE CONTENTS OF THIS DOCUMENT AND THE EFFECT OF THIS GRANT OF POWERS TO MY AGENT.

My Signature: _____

Date signed: _____

TWO WITNESSES

I declare, on the basis of information and belief, that the person who signed or acknowledged this document (the principal) is personally known to me, that principal signed or acknowledged this health care power of attorney in my presence, and that principal appears to be of sound mind and under no duress, fraud, or undue influence. I am not related to the principal by blood, marriage, or adoption, either as a spouse, a lineal ancestor, descendant of the parents of the principal, or spouse of any of them. I am not directly financially responsible for the principal's medical care. I am not entitled to any portion of the principal's estate upon his decease, whether under any will or as an heir by intestate succession, nor am I the beneficiary of an insurance policy on the principal's life, nor do I have a claim against the principal's estate as of this time. I am not the principal's attending physician, nor an employee of the attending physician. No more than one witness is an employee of a health care facility in which the principal is a patient. I am not appointed as health care agent or successor health care agent by this document.

Witness One Signature: _____

Witness One Printed Name: _____

Witness One Address: _____

Witness One Phone: _____

Witness Two Signature: _____

Witness Two Printed Name: _____

Witness Two Address: _____

Witness Two Phone: _____

AND

NOTARY PUBLIC

State of South Carolina

County of _____

The foregoing instrument was acknowledged before me by FirstName LastName on _____
_____ (date).

Notary Public Signature: _____

Notary Public for South Carolina

My Commission Expires: _____