Legal Forms & Services

FirstName LastName

HAWAII
HEALTH CARE DIRECTIVE

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

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

Option 2: Notary Only
1. Print out your document
2. Review, initial, sign, and date in front of a notary
3. Have notary sign and date
4. 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, 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. Review your state's laws on witness requirements for health care directives.

LIVING WILL

FOR

FirstName LastName

This document includes the following:

Power of attorney for health care designating a health care 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.

Health care instructions to guide those making health care decisions on my behalf in the event I am unable to communicate or make my health care decisions on my own.

PART 1
POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

DESIGNATION OF AGENT. I, FirstName LastName, designate the following individual as my agent to make health care decisions for me:

Name: FirstName LastName

Relationship: Spouse

Address: 111 Street Address

City, Hawaii 12345

Phone: 1111111111

Email: emailaddress@email.com

OPTIONAL. If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health care decision for me, I designate as my first alternate agent:

Name: FirstName LastName

Relationship: Son

Address: 333 Street Address

City, Hawaii 12345

Phone: 111111111

Email: emailaddress@email.com

AGENT'S AUTHORITY. Generally, my agent is authorized to make all health care decisions for me, except as I state here:

Limitations on Health Care Agent's Authority:

I do not wish to limit the authority of my health care agent at this time.

WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE. My agent's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions.

AGENT'S OBLIGATION. My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

PART 2
INSTRUCTIONS FOR HEALTH CARE

END-OF-LIFE DECISIONS. I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below: (Check and initial only one box.)

_____☑ Choice Not to Prolong Life
I do not want my life to be prolonged if (i) I have an incurable and irreversible condition that will result in my death within a relatively short time, (ii) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (iii) the likely risks and burdens of treatment would outweigh the expected benefits, OR

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

ARTIFICIAL NUTRITION AND HYDRATION. _____☑ Artificial nutrition and hydration must be withheld or withdrawn, regardless of my condition.

RELIEF FROM PAIN. _____☑ I direct that treatment to alleviate pain or discomfort should be provided to me, even if it hastens my death.

OTHER WISHES.
I do not have other wishes at this time.

PART 3
DONATION OF ORGANS AT DEATH

Upon my death:

_____☑ I want to donate my organs and tissue.

SIGNATURES

This document must be signed and dated by me. It also must either be verified by two witnesses (Option 1) OR a notary public (Option 2). It must be signed and dated when it is witnessed or verified. One of my witnesses must not be related to me by blood, marriage, or adoption nor entitled to any portion of my estate under any will or codicil or by operation of law.

I, FirstName LastName, sign this directive voluntarily and declare I am capable of understanding the instructions I have given and the choices I have made therein. I understand that I may revoke this directive at any time prior to my incapacity.

My Signature: ______________________________

Date signed: _______________________________

If I cannot sign my name, I ask the below named person to sign for me.

Signature: _________________________________

Printed Name:______________________________

TWO WITNESSES (OPTION 1)

Witness One. In my presence on ___________________________ (date), FirstName LastName acknowledged his/her/their signature on this document or acknowledged that he/she/they authorized the person signing this document to sign on his/her/their behalf. I certify the following:

- I am not named as a health care agent or an alternate health care agent in this document.
- I am not an employee of the principal’s health care provider or a facility providing health care to the principal.

Witness One Signature: ______________________________

Witness One Printed Name: __________________________

Witness One Address: _______________________________

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Witness One Phone: _________________________________

Witness Two. In my presence on ____________________________ (date), FirstName LastName acknowledged his/her/their signature on this document or acknowledged that he/she/they authorized the person signing this document to sign on his/her/their behalf. I certify the following:

- I am not named as a health care agent or an alternate health care agent in this document.
- I am not an employee of the principal's health care provider or a facility providing health care to the principal.
- I am not related to the principal by blood, marriage, or adoption.
- I am not entitled to any portion of the principal's estate under any will or codicil or by operation of the law.

Witness Two Signature: ______________________________

Witness Two Printed Name: __________________________

Witness Two Address: _______________________________

____

Witness Two Phone: _________________________________

OR

NOTARY PUBLIC (OPTION 2)

State of _______________________________

County of _____________________________

In my presence on ___________________________ (date) FirstName LastName acknowledged his/her/their signature on this document or acknowledged that he/she/they authorized the person signing this document to sign on his/her/their behalf within the state of Hawaii.

Notary Public Signature: __________________________________

Commission Expiration Date: ______________________________