FirstName LastName

IDAHO
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 Idaho

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
3. 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:

Living will with 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.

Power of attorney for health care designating a health care agent or attorney in fact 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.

Date: _____

Name: FirstName LastName

Address: 111 Street Address, City, Idaho, 12345

A LIVING WILL

A Directive to Withhold or to Provide Treatment

1. I willfully and voluntarily make known my desire that my life shall not be prolonged artificially under the circumstances set forth below. This directive shall only be effective if I am unable to communicate my instructions and:

a. I have an incurable or irreversible injury, disease, illness or condition, and a medical doctor who has examined me has certified:

1. That such injury, disease, illness or condition is terminal; and

2. That the application of artificial life-sustaining procedures would serve only to prolong artificially my life; and

3. That my death is imminent, whether or not artificial life-sustaining procedures are utilized; or

b. I have been diagnosed as being in a persistent vegetative state.

In such event, I direct that the following marked expression of my intent be followed, and that I receive any medical treatment or care that may be required to keep me free of pain or distress.

Select and initial one choice:

☐ I direct that all medical treatment, care and procedures necessary to restore my health and sustain my life be provided to me. Nutrition and hydration, whether artificial or non-artificial, shall not be withheld or withdrawn from me if I would likely die primarily from malnutrition or dehydration rather than from my injury, disease, illness or condition.

OR

☐ I direct that all medical treatment, care and procedures, including artificial life-sustaining procedures, be withheld or withdrawn, except that nutrition and hydration, whether artificial or non-artificial shall not be withheld or withdrawn from me if, as a result, I would likely die primarily from malnutrition or dehydration rather than from my injury, disease, illness or condition, as follows: (If none of the following boxes are checked and initialed, then both nutrition and hydration, of any nature, whether artificial or non-artificial, shall be

Select and initial one choice:

☐ A. Only hydration of any nature, whether artificial or non-artificial, shall be administered;

☐ B. Only nutrition, of any nature, whether artificial or non-artificial, shall be administered;

☐ C. Both nutrition and hydration, of any nature, whether artificial or non-artificial shall be administered.

OR

_____☑ I direct that all medical treatment, care and procedures be withheld or withdrawn, including withdrawal of the administration of artificial nutrition and hydration.

2. I understand the full importance of this directive and am mentally competent to make this directive. No participant in the making of this directive or in its being carried into effect shall be held responsible in any way for complying with my directions.

A POWER OF ATTORNEY FOR HEALTH CARE

1. DESIGNATION OF HEALTH CARE AGENT. None of the following may be designated as your agent: (1) your treating health care provider; (2) a nonrelative employee of your treating health care provider; (3) an operator of a community care facility; or (4) a nonrelative employee of an operator of a community care facility. If the agent or an alternate agent designated in this directive is my spouse, and our marriage is thereafter dissolved, such designation shall be thereupon revoked.

I do hereby designate and appoint the following individual as my attorney in fact (agent) to make health care decisions for me as authorized in this directive:

Name: FirstName LastName

Relationship: Spouse

Address: 111 Street Address

City, Idaho 12345

Phone: 1111111111

Email: emailaddress@email.com

2. DESIGNATION OF ALTERNATE AGENTS. If the person designated as my agent in paragraph 1 is not available or becomes ineligible to act as my agent to make a health care decision for me or loses the mental capacity to make health care decisions for me, or if I revoke that person's appointment or authority to act as my agent to make health care decisions for me, then I designate and appoint the following persons to serve as my agent to make health care decisions for me as authorized in this directive, such persons to serve in the order listed below:

Name: FirstName LastName

Relationship: Son

Address: 333 Street Address

City, Idaho 12345

Phone: 1111111111

Email: emailaddress@email.com

For the purposes of this directive, “health care decision” means consent, refusal of consent, or withdrawal of consent to any care, treatment, service or procedure to maintain, diagnose or treat an individual's physical condition.

3. CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE. By this portion of this directive, I create a power of attorney for health care. This power shall be effective only when I am unable to communicate rationally.

4. GENERAL STATEMENT OF AUTHORITY GRANTED. I hereby grant to my agent full power and authority to make health care decisions for me to the same extent that I could make such decisions for myself if I had the capacity to do so. In exercising this authority, my agent shall make health care decisions that are consistent with my desires as stated in this directive or

otherwise made known to my agent including, but not limited to, my desires concerning obtaining or refusing or withdrawing artificial life-sustaining care, treatment, services and procedures, including such desires set forth in a living will, or similar document executed by me, if any. (If you want to limit the authority of your agent to make health care decisions for you, you can state the limitations in paragraph 4 ("Statement of Desires, Special Provisions, and Limitations") below.

5. STATEMENT OF DESIRES, SPECIAL PROVISIONS, AND LIMITATIONS. (Your agent must make health care decisions that are consistent with your known desires. You can, but are not required to, state your desires in the space provided below. You should consider whether you want to include a statement of your desires concerning artificial life-sustaining care, treatment, services and procedures. You can also include a statement of your desires concerning other matters relating to your health care, including a list of one or more persons whom you designate to be able to receive medical information about you and/or to be allowed to visit you in a medical institution. You can also make your desires known to your agent by discussing your desires with your agent or by some other means. If there are any types of treatment that you do not want to be used, you should state them in the space below. If you want to limit in any other way the authority given your agent by this directive, you should state the limits in the space below. If you do not state any limits, your agent will have broad powers to make health care decisions for you, except to the extent that there are limits provided by law.) In exercising the authority under this power of attorney for health care, my agent shall act consistently with my desires as stated below, a living will, or similar document executed by me, if any.

Additional statement of desires, special provisions, and limitations:

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

6. INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY HEALTH.

A. General Grant of Power and Authority. Subject to any limitations in this directive, my agent has the power and authority to do all of the following:

- Request, review and receive any information, verbal or written, regarding my physical or mental health including, but not limited to, medical and hospital records
- Execute on my behalf any releases or other documents that may be required in order to obtain this information
- Consent to the disclosure of this information
- Consent to the donation of any of my organs for medical purposes

B. HIPAA Release Authority. My agent shall be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. 1320d and 45 CFR 160 through 164. I authorize any physician, health care professional, dentist,

health plan, hospital, clinic, laboratory, pharmacy, or other covered health care provider, any insurance company, 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, to give, disclose and release to my agent, without restriction, all of my individually identifiable health information and medical records regarding any past, present or future medical or mental health condition, including all information relating to the diagnosis of HIV/AIDS, sexually transmitted diseases, mental illness, and drug or alcohol abuse. The authority given my agent shall supersede any other agreement that I may have made with my health care providers to restrict access to or disclosure of my individually identifiable health information. The authority given my agent has no expiration date and shall expire only in the event that I revoke the authority in writing and deliver it to my health care provider.

7. SIGNING DOCUMENTS, WAIVERS AND RELEASES. Where necessary to implement the health care decisions that my agent is authorized by this directive to make, my agent has the power and authority to execute on my behalf any necessary waiver or release from liability required by a hospital or physician.

8. PRIOR DESIGNATIONS REVOKED. I revoke any prior durable power of attorney for health care.

SIGNATURES

This document must be signed and dated by me.

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: _____