Legal Forms & Services

FirstName LastName

NEW MEXICO
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 New Mexico
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
3. Have witnesses 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:

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.

Designation of 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

PART 1

POWER OF ATTORNEY FOR HEALTH CARE

DESIGNATION OF AGENT: I, FirstName LastName, being an adult or emancipated minor of sound mind, designate the following individual to make health care decisions for me:

Name: FirstName LastName

Relationship: Spouse

Address: 111 Street Address
City, New Mexico 11111

Phone 1111111111

Email: emailaddress@email.com

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: 222 Street Address
City, New Mexico 11111

Phone: 1111111111

Email: emailaddress@email.com

AGENT'S AUTHORITY: My agent is authorized to obtain and review medical records, reports and information about me and to make all health-care decisions for me, including decisions to provide, withhold or withdraw artificial nutrition, hydration and all other forms of health care to keep me alive, except as I state here:

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 care practitioner and one other qualified health-care professional determine 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.

NOMINATION OF GUARDIAN: If a guardian of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able or reasonably available to act as guardian, I nominate the alternate agents whom I have named, in the order designated.

PART 2

INSTRUCTIONS FOR HEALTH CARE

END-OF-LIFE-DECISIONS: If I am unable to make or communicate decisions regarding my health care, and IF (i) I have an incurable or irreversible condition that will result in my death within a relatively short time, OR (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, THEN I direct that my health-care practitioners and others involved in my care provide, withhold or withdraw treatment in accordance with the choice I have initialed below in one of the following three boxes:

_____☑ I CHOOSE NOT TO PROLONG LIFE.
I do not want my life to be prolonged.

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

☐ I CHOOSE TO LET MY AGENT DECIDE.
My agent under my power of attorney for health care may make life-sustaining treatment decisions for me.

ARTIFICIAL NUTRITION AND HYDRATION: If I have chosen above NOT to prolong life, I also specify by marking my initials below:

_____☑ I DO NOT WANT artificial nutrition.

☐ I DO WANT artificial nutrition.

_____☑ I DO NOT WANT artificial hydration, unless required for my comfort.

☐ I DO WANT artificial hydration.

RELIEF FROM PAIN: Regardless of the choices I have made in this form and except as I state in the following space, I direct that the best medical care possible to keep me clean, comfortable and free of pain or discomfort be provided at all times so that my dignity is maintained, even if this care hastens my death:

I do not wish to state exceptions to relief from pain at this time.

ANATOMICAL GIFT SELECTION: Upon my death I specify as marked below whether I choose to make an anatomical gift of all or some of my organs or tissue:

_____☑ I WANT to donate my organs and tissue.

OTHER WISHES:

I do not wish to leave additional instructions at this time.

PRIMARY CARE PRACTITIONER

I do not wish to designate a primary care practitioner at this time.

EFFECT OF COPY: A copy of this form has the same effect as the original.

REVOCATION: I understand that I may revoke this OPTIONAL HEALTH CARE DIRECTIVE at any time and that if I revoke it, I should promptly notify my supervising health care practitioner and any health care institution where I am receiving care and any others to whom I have given copies of this power of attorney. I understand that I may revoke the designation of an agent either by a signed writing or by personally informing the supervising health care practitioner.

SIGNATURES: Sign and date the form here:

This document must be signed and dated by me. It should also be verified by two witnesses and signed and dated when it is witnessed.

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.

Date	Sign Your Name
Street Address	Print Your Name
City, State	Your Social Security Number

SIGNATURE OF WITNESSES

First Witness	Second Witness
Print Name	Print Name
Street Address	Street Address
City, State	City, State
Signature	Signature
Date	Date