Pennsylvania

Advance Health Care Directive Law

(Health Care Power of Attorney and Living Will Included)

A Message from

SENATOR WAYNE D. FONTANA

42nd Senatorial District

Dear Constituent:

Under changes made to state law in 2006, the types of Advance Health Care Directives recognized in Pennsylvania have been expanded.

To ensure that your medical treatment wishes will be carried out if you become unable to make or communicate them, you now may appoint another person to make them for you through a Durable Health Care Power of Attorney. This is in addition to the recognition previously granted to Living Wills to direct the use of life support and other treatments in case of permanent unconsciousness or terminal illness.

This brochure includes a combined Durable Health Care Power of Attorney and Living Will, modeled on a form in the 2006 law authorizing them. That does not mean your Advance Health Care Directive must be in this form, or that it can't include other directions you prefer. Also, if you already have a Living Will, you do not need to change it.

In deciding whether to make an Advance Health Care Directive, you will probably want to consult with one or more of the following: Your family, doctor, clergy and/or attorney. You should give a copy to your doctor, family members and others you expect will attend to you. If your wishes change, be sure to tell your doctor and prepare a new advance health care directive.

It is my hope that this will help you in considering this very personal decision.

As always, if my office can be of further assistance on this or any other issue pertaining to state government, please don't hesitate to write or call.

Sincerely,

Wayne D. Fontana

WAYNE D. FONTANA
State Senator—42nd District

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ADVANCE HEALTH CARE DIRECTIVES

Pennsylvania recognizes two forms of Advance Health Care Directives: **Durable Health Care Powers of Attorney** and **Living Wills**. Any person of sound mind who is at least 18 years old, a high school graduate or married can make an Advance Health Care Directive for the health care he or she wishes to receive. The person making the directive, or another person on his or her behalf and at his or her direction, either must sign it before two witnesses who are at least 18 years old or have it notarized. A witness cannot sign the directive on behalf of or at the direction of its subject. A health care provider must follow the instructions or indicate his refusal to do so and help transfer the person to another provider who will honor them. Health Care providers and Health Care Agents (discussed below) following the instructions in good faith, are protected from legal liability, other than for negligence or failing to meet professional standards. An Advance Health Care Directive may be revoked at any time by notifying the attending physician, health care provider or other witness to the revocation. Life-sustaining treatment must be provided to a pregnant woman regardless of such instructions until the birth of the child, unless doing so would physically harm her or cause her pain that could not be alleviated by medication, or would prevent the continuing development and birth of the child.

Durable Health Care Power of Attorney

A Durable Health Care Power of Attorney is a written instruction naming another person to act as your Health Care Agent. You decide what health care authority the agent will have and when he or she will have it. It allows you to tell your agent what types of care you would find burdensome and undesirable, or whether medical care should be applied aggressively if you have an extreme and irreversible condition such as Alzheimer's Disease. You remain responsible for the costs of the care. A health care agent should be someone likely to be available if and when you cannot make your own decisions. You should inform the agent when you have appointed him or her and discuss your beliefs and values to ensure that he or she understands and will try to meet your objectives. **Note: Health care providers may be agents only for their own relatives.**

Living Wills

Living Wills are intended to ease the burden of medical decision-making for loved ones by allowing you to direct beforehand what artificial life supports or extraordinary medical treatments are to be used should you develop an end-stage condition (become terminally ill) or fall into an irreversible coma or permanent unconsciousness. They take effect only at that time.

ABOUT THIS FORM

The Advance Health Care Directive here is not intended as specific legal or medical advice, for which you should rely on your attorney or physician. If you are unclear about the meaning of statements in it or their impact on you, you should consult your attorney or health care provider as appropriate. The Durable Health Care Power of Attorney section gives your health care agent the *immediate* right to know information about your physical and mental health from your health care providers, and broad powers to make treatment decisions for you when, and only when, you become unable to understand, make or communicate health care decisions. The Living Will section expresses a desire to restrict the care to be provided to you if you become permanently unconscious or have an end-stage condition.

If you do not wish to give your health care agent immediate authority to have information about your health, broad powers or do not wish to restrict care in case of permanent unconsciousness or an end-stage condition, or if you wish to allow your health care agent to immediately be able to make decisions for you or wish to state more detailed preferences than this form provides, you should not use this form.

ADVANCE HEALTH CARE DIRECTIVE

DURABLE HEALTH CARE POWER OF ATTORNEY

I, _____ , of _____ County,

(Please print name)

Pennsylvania, appoint the person named below as my health care agent to make health and personal care decisions for me.

■ RIGHT TO HEALTH CARE INFORMATION

Effective *immediately and continuously* until my death or a signed, written revocation 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 at his or her request any oral or written information regarding my physical or mental health, including medical and hospital records and otherwise private, privileged, protected or personal health information—such as defined and described in the federal Health Insurance Portability and Accountability Act of 1996, regulations promulgated thereunder, and any other federal, 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.

■ POWERS OF HEALTH CARE AGENT

My health care agent shall have the following powers when my attending physician verifies that I lack the ability to understand, make or communicate a choice regarding a health or personal care decision. My health care agent may not delegate this authority to make decisions.

*Cross out and initial those powers that you do **not** want to give:*

_____ 1. To authorize, withhold or withdraw medical care and surgical procedures.

_____ 2. To authorize, withhold or withdraw nutrition (food) or hydration (water) medically supplied by tube through my nose, stomach, intestines, arteries or veins.

_____ 3. 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.

_____ 4. To hire and fire medical, social service and other support personnel responsible for my care.

_____ 5. To take any legal action necessary to do what I have directed.

_____ 6. 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

(If you do not name a health care agent, a family member or an adult who knows your preferences and values will be asked for help in determining your treatment wishes). **I appoint the following person as my health care agent:**

_____

Health Care Agent (Name and relationship)

_____

Address

_____

Telephone Number (Home and Work) E-mail

If my health care agent is not readily available, or is my spouse and an action for divorce is filed between us after this date, I appoint the following in the order indicated. *(It is helpful, but not required to name alternative health care agents.)*

_____

First Alternative Health Care Agent (Name and relationship)

_____

Address

_____

Telephone Number (Home and Work) E-mail

_____

Second Alternative Health Care Agent (Name and relationship)

_____

Address

_____

Telephone Number (Home and Work) E-mail

■ GUIDANCE TO HEALTH CARE AGENT

If I have an end-stage medical condition or other extreme irreversible medical condition, my goals in making medical decisions are as follows *(insert personal priorities, such as comfort, care, preservation of mental function, etc.):*

_____

_____

_____

■ SEVERE BRAIN DAMAGE OR BRAIN DISEASE

I consider suffering from severe and irreversible brain damage or brain disease with no realistic hope of significant recovery to be intolerable, and aggressive medical care for it to be burdensome. I therefore request my health care agent to respond to any intervening life-threatening conditions in such circumstances as I have directed for an end-stage medical condition or a state of permanent unconsciousness.

LIVING WILL

The following health treatment instructions exercise my right to make my own health care decisions and are intended as clear and convincing evidence of my wishes when I lack the capacity to understand, make or communicate my treatment decisions.

■ IF I HAVE AN END-STAGE MEDICAL CONDITION (one which will result in my death, despite the introduction or continuation of medical treatment) OR I AM PERMANENTLY UNCONSCIOUS SUCH AS BEING IN AN IRREVERSIBLE COMA OR AN IRREVERSIBLE VEGETATIVE STATE, AND THERE IS NO REALISTIC HOPE OF SIGNIFICANT RECOVERY:

*Cross out and initial treatment instructions with which you do **not** agree.*

_____ **I direct that I be given health care treatment for pain relief or comfort even if it might shorten my life, suppress my appetite or my breathing, or be habit-forming.**

_____ **I direct that all life-prolonging procedures be withheld or withdrawn.**

■ IN ADDITION, IF I AM IN THE CONDITION DESCRIBED ABOVE:

I ☐ DO ☐ DO NOT want cardiac resuscitation.

I ☐ DO ☐ DO NOT want blood or blood products.

I ☐ DO ☐ DO NOT want tube feeding or any other artificial or invasive form of nutrition (food) or hydration (water).

I ☐ DO ☐ DO NOT want mechanical respiration.

I ☐ DO ☐ DO NOT want kidney dialysis.

I ☐ DO ☐ DO NOT want antibiotics.

I ☐ DO ☐ DO NOT want any form of surgery or invasive diagnostic tests.

I ☐ DO ☐ DO NOT want chemotherapy.

I ☐ DO ☐ DO NOT want radiation treatment.

I realize that if I do not specifically indicate my preference regarding any of the forms of treatment listed above, I may receive that form of treatment.

■ MY HEALTH CARE AGENT, IF I HAVE APPOINTED ONE, *(check only one)*

_____ must follow these instructions.

_____ shall have final say and may override any of my instructions except:

_____

■ IF I DID NOT APPOINT A HEALTH CARE AGENT, THESE INSTRUCTIONS SHALL BE FOLLOWED.

ORGAN DONATION

(Check Only One)

_____ **I consent to donate my organs and tissues at the time of my death for the purpose of transplant, medical study or education, subject to:** *(Insert any limitations you desire on the donation of specific organs or tissues or uses for donated organs and tissues).*

_____

_____ **I do not consent to donate my organs or tissues at the time of my death.**

DECLARATION

I made this declaration on the _____ day of _____ (month, year).

_____
Declarant's signature:

_____
Declarant's address:

_____

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.

_____
Witness's signature:

_____
Witness's address:

_____

_____
Witness's signature:

_____
Witness's address:

_____