ADVANCE DIRECTIVE

YOU DO NOT HAVE TO FILL OUT AND SIGN THIS FORM

PART A: IMPORTANT INFORMATION ABOUT THIS ADVANCE DIRECTIVE

This is an important legal document. It can control critical decisions about your health care. Before signing, consider these important facts:

Facts About Part B (Appoint a Health Care Representative)

You have the right to name a person to direct your health care when you cannot do so. This person is called your "health care representative". You can do this by using Part B of this form. Your representative must accept on Part E of this form.

You can write in this document any restrictions you want on how your representative will make decisions for you. Your representative must follow your desires as stated in this document or otherwise made known. If your desires are unknown, your representative must try to act in your best interest. Your representative can resign at any time.

Facts About Part C (Giving Health Care Instruction)

You also have the right to give instructions for health care providers to follow if you become unable to direct your care. You can do this by using Part C of this form.

Facts About Completing this Form

This form is valid only if you sign it voluntarily and when you are of sound mind. If you do not want an advance directive, you do not have to sign this form.

Unless you have limited the duration of this advance directive, it will not expire. If you have set an expiration date, and you become unable to direct your health care before that date, this advance directive will not expire until you are able to make those decisions again.

You may revoke this document at any time. To do so, notify your representative and your health care provider of the revocation.

Despite this document, you have the right to decide your own health care as long as you are able to do so.

If there is anything in this document that you do not understand, ask a lawyer to explain it to you.

You may sign PART B, PART C, or both parts. You may cross out words that don't express your wishes or add words that better express your wishes. Witnesses must sign PART D.

_____
<NAME>

_____
(Date of Birth)

Address: <>

Unless revoked or suspended, this advance directive will continue for:

INITIAL ONE:

_____ My entire life
_____ Other period (____ Years)

PART B: APPOINTMENT OF HEALTH CARE REPRESENTATIVE

I appoint <first> as my health care representative. My representative's address is _____, and telephone number is _____.

I appoint <second> as my alternate health care representative. My alternate's address is _____, and telephone number is _____.

I appoint <third> as my second alternate health care representative. My alternate's address is _____, and telephone number is _____.

I authorize my representative (or alternate) to direct my health care when I can't do so.

NOTE: You may not appoint your doctor, an employee of your doctor, or an owner, operator or employee of your health care facility, unless that person is related to you by blood, marriage or adoption or that person was appointed before your admission into the health care facility.

1. Limits.

Special Conditions or Instructions:_____
_____
_____.

INITIAL IF THIS APPLIES:

_____ I have executed a Health Care Instruction or Directive to Physicians. My representative is to honor it.

2. Life Support.

"Life support' refers to any medical means for maintaining life, including procedures, devices and medications. If you refuse life support, you will still get routine measures to keep you clean and comfortable.

INITIAL IF THIS APPLIES:

_____ My representative MAY decide about life support for me. (If you don't initial this space, then your representative MAY NOT decide about life support).

3. Tube Feeding.

One sort of life support is food and water supplied artificially by medical device, known as tube feeding.

INITIAL IF THIS APPLIES:

_____ My representative MAY decide about tube feeding for me. (IF you don't initial this space, then your representative MAY NOT decide about tube feeding).

DATED: <date>

SIGN HERE TO APPOINT A HEALTH CARE REPRESENTATIVE

_____

<NAME>

PART C: HEALTH CARE INSTRUCTIONS

NOTE: In filling out these instructions, keep the following in mind:

* The term "as my physician recommends" means that you want your physician to try life support if your physician believes it could be helpful and then discontinue it if it is not helping your health condition or symptoms.

* "Life support" and "tube feeding" are defined in Part B above.

* If you refuse tube feeding, you should understand that malnutrition, dehydration and death will probably result.

* You will get care for your comfort and cleanliness, no matter what choices you make.

* You may either give specific instructions by filling out Items 1 to 4 below, or you may use the general instruction provided by Item 5.

Here are my desires about my health care if my doctor and another knowledgeable doctor confirm that I am in a medical condition described below:

1. Close to Death. If I am close to death and life support would only postpone that moment of my death:

A. INITIAL ONE:
_____ I want to receive tube feeding.
_____ I want tube feeding only as my physician recommends.
_____ I **DO NOT WANT** tube feeding.

B. INITIAL ONE:
_____ I want any other life support that may apply.
_____ I want life support only as my physician recommends.
_____ I want **NO** life support.

2. Permanently Unconscious. If I am unconscious and it is very unlikely that I will ever become conscious again:

A. INITIAL ONE:
_____ I want to receive tube feeding.
_____ I want tube feeding only as my physician recommends.
_____ I **DO NOT WANT** tube feeding.

B. INITIAL ONE:

_____ I want any other life support that may apply.
_____ I want life support only as my physician recommends.
_____ I want **NO** life support.

3. Advanced Progressive Illness. If I have a progressive illness that will be fatal and is in an advanced stage, and I am consistently and permanently unable to communicate by any means, swallow food and water safely, care for myself and recognize my family and other people, and it is very unlikely that my condition will substantially improve:

A. INITIAL ONE:

_____ I want to receive tube feeding.
_____ I want tube feeding only as my physician recommends.
_____ I **DO NOT WANT** tube feeding.

B. INITIAL ONE:

_____ I want any other life support that may apply.
_____ I want life support only as my physician recommends.
_____ I want **NO** life support.

4. Extraordinary Suffering. If life support would not help my medical condition and would make me suffer permanent and severe pain:

A. INITIAL ONE:

_____ I want to receive tube feeding.
_____ I want tube feeding only as my physician recommends.
_____ I **DO NOT WANT** tube feeding.

B. INITIAL ONE:

_____ I want any other life support that may apply.
_____ I want life support only as my physician recommends.
_____ I want **NO** life support.

5. General Instruction.

_____ I do not want my life to be prolonged by life support. I also do not want tube feeding as life support. I want my doctors to allow me to die naturally if my doctor and another knowledgeable doctor confirm I am in any of the medical conditions listed in Items 1 to 4 above.

6. Additional Conditions or Instructions.

SEE REGARDING MY PERSON ON PAGE 9.

(Insert description of what you want done).

7. Other Documents. A "health care power of attorney" is any document you may have signed to appoint a representative to make health care decisions for you.

INITIAL ONE:

_____ I have previously signed a health care power of attorney. I want it to remain in effect unless I appointed a health care representative after signing the health care power of attorney.

_____ I have a health care power of attorney, and I REVOKE IT.

_____ **I DO NOT** have a health care power of attorney.

DATED: <date>

SIGN HERE TO GIVE INSTRUCTIONS

_____

<NAME>

PART D: DECLARATION OF WITNESSES

We declare that the person signing this advance directive:

(a) Is personally known to us or has provided proof of identity;
(b) Signed or acknowledged that person's signature on this advance directive in our presence;
(c) Appears to be of sound mind and not under duress, fraud or undue influence;
(d) Has not appointed either of us as health care representative or alternative representative; and
(e) Is not a patient for whom either of us is attending physician.

Witnessed by:

_____ _____

(Signature of Witness) (Printed Name of Witness)
DATE: <date>

_____ _____

(Signature of Witness) (Printed Name of Witness)
DATE: <date>

NOTE: One witness must not be a relative (by blood, marriage or adoption) of the person signing this advance directive. That witness must also not be entitled to any portion of the person's estate upon death. That witness must also not own, operate or be employed at a health care facility where the person is a patient or resident.

PART E: ACCEPTANCE BY HEALTH CARE REPRESENTATIVE

I accept this appointment and agree to serve as health care representative. I understand I must act consistently with the desires of the person I represent, as expressed in this advance directive or otherwise made known to me. If I do not know the desires of the person I represent, I have a duty to act in what I believe in good faith to be that person's health care only while that person cannot do so. I understand that the person who appointed me may revoke this appointment. If I learn that this document has been suspended or revoked, I will inform the person's current health care provider if known to me.

_____ Date:_____
<first>

_____ Date:_____
<second>

_____ Date:_____
<third>

REGARDING MY PERSON

My agent shall have the authority regarding my person, in the event of my incapacity, to make all decisions that a court-appointed guardian would have the authority to make under the laws of the State of Oregon, including, but not limited to the authority to:

(A) To request, receive and review any information, verbal or written, regarding my physical or mental health, including medical and hospital records, to execute any releases or other documents necessary to obtain such information, and to disclose information regarding my physical or mental health to appropriate health care professionals.

(B) To employ and discharge medical personnel including physicians, psychiatrists, dentists, nurses and therapists for my physical, mental and emotional well-being, and to pay them (or cause them to be paid) reasonable compensation from my funds.

(C) To give or withhold consent to any medical procedure consistent with any Health Care Directive currently in effect, including surgery, except as specified below; to arrange for my hospitalization, convalescent care, hospice, nursing home or home care; to summon paramedics or other emergency personnel and seek emergency treatment; and, under circumstances in which the agent determines that certain medical procedures, tests or treatments are no longer of any benefit or where the benefits are outweighed by the burdens imposed, to revoke, withdraw, modify or change consent to such procedures, tests and treatments, as well as hospitalization, convalescent care, hospice or home care which I or the agent may have previously allowed or consented to or which may have been implied due to emergency conditions.

(D) To arrange for voluntary admission of myself to an appropriate hospital or institution for treatment of mental disorders, alcoholism, or drug abuse if two (2) independent psychiatrists examine me and certify that I am in immediate need of hospitalization or institutional care for the diagnosed problem or disorder; to arrange for private psychiatric and psychological treatment for myself; to refuse consent for any such hospitalization, institutionalization and private psychiatric and psychological care, and to revoke, modify, withdraw or change consent to such hospitalization, institutionalization and private treatment which the agent or I may have given at an earlier time.

(E) To request that aggressive medical therapy not be instituted or be discontinued, including (but not limited to) cardiopulmonary resuscitation, the implantation of a cardiac pacemaker, renal dialysis, parenteral feeding, the use of respirators or ventilators, blood transfusions, nasogastric tube use, intravenous feedings, endotracheal tube use, antibiotics, and organ transplants. The agent should try to discuss the specifics of any such decision with me if I am able to communicate with the agent in any manner, even by blinking my eyes. If I am unconscious, comatose, senile, or otherwise unreachable by such communication, the agent should make the decision guided primarily by any preferences which I may have previously expressed and secondarily by the information given by the physicians treating me as to my medical diagnosis and prognosis. The agent may specifically request and concur with the writing of a "no-code" (Do Not Resuscitate) order to physicians and hospital and a EMS - No CPR form to emergency medical personnel to not attempt cardio-pulmonary resuscitation.

(F) To arrange for and oversee my placement in a nursing home, retirement home or other such extended care facility when and for such time as I may require professional assistance with daily living activities due to incapacity and such placement is either consented to by me or recommended by my attending physician, in writing, and such recommendation is based upon my best interests of my health, safety, and well-being. Incapacity for this purpose means that I am unable to handle the activities of daily living and require long term care and assistance.

(G) To exercise my right of privacy and my right to make decisions regarding treatment even though the exercise of my rights might hasten my death or be against conventional medical advice.

(H) To consent to and arrange for the administration of pain-relieving drugs of any kind or other surgical or medical procedures calculated to relieve my pain, including unconventional pain-relief therapies which the agent believes may be helpful, even though these drugs or procedures may lead to permanent physical damage, addiction or hasten the moment of my death.

(I) To grant, in conjunction with any instructions given hereunder, releases to hospital staff, physicians, nurses and other medical and hospital administrative personnel who act in reliance on instructions given by the agent or who render written opinions to the agent in connection with any matter described in this article from all liability from damages suffered or to be suffered by me, to sign documents titled or purporting to be a "Refusal to Treatment" or "Leaving Hospital Against Medical Advice", as well as any necessary waivers of or releases from liability required by a hospital or physician to implement my wishes regarding medical treatment or non-treatment.

ADDENDUM TO THE ADVANCE DIRECTIVE
OF
<NAME>

HEALTH INSURANCE AND PORTABILITY AND ACCOUNTABILITY ACT OF 1996

I am aware of my privacy rights under the Health Insurance Portability and Accountability Act of 1996, as implemented by Rules and Regulations issued by the Department of Health and Human Services, especially as provided in 45 CFR 164.502, as such Act and such Rules and Regulations may be amended from time to time, ("HIPAA"). Specifically in relation to HIPAA, in addition to other powers granted under this Directive, I state as follows:

I grant to those I have named to serve as my health care representative in my Advance Directive the power and authority to serve as my personal representative for all purposes under HIPAA; and I authorize those individuals to make requests for, have access to, and to receive my medical and personal information in any form from any individual or organization covered by HIPAA.

Upon such request, any individual or organization covered by HIPAA and its regulations shall disclose *all information* pertaining to me, including, without limitation, all medical information, medical records, and medical billings on my behalf as well as anything related to my medical information, medical records, and medical billings including my diagnosis, prognosis, and recommended treatment options, and recommendations, hereafter referred to collectively as "*Medical Information*". The term "medical," as used herein shall include the physical, the emotional and the mental. This authorization is intended to comply with HIPAA and all other federal and state and local laws, regulations, statutes, and codes related to privacy and the release of medical information. This authorization shall be liberally construed to allow those named in my Advance Directive to receive any and all requested Medical Information concerning me.

If a medical doctor is requested to render an opinion regarding my health condition (whether mental or physical) and thereby certifies in writing that I am disabled pursuant to the terms of this Directive, I, on behalf of myself and my heirs and assigns, waive any and all liability and hold the physician, hospital and/or health care provider free, clear and harmless for rendering such an opinion.

I authorize my physician, hospital and/or health care provider to fully and freely discuss my health situation, including but not limited to my physical and mental health, with those named in my Advance Directive (or their designee) and I hold said physician, hospital and/or health care provider free, clear and harmless from any liability for same.

This authorization shall continue until revoked in writing in either a written document signed by me, or a written document signed by my Personal Representative, delivered to such individual or organization covered by HIPAA. Either my Personal Representative or I have an unlimited right to revoke this authorization in a writing signed and dated by me or my Personal Representative. There are no exceptions to this right to revoke this authorization.

I understand that information used or disclosed pursuant to this authorization may be redisclosed by my authorized recipient(s) and, therefore, may no longer be protected by HIPAA.

For purposes of this section, the term "Personal Representative" means my personal representative as defined by HIPAA.

DATED: <date>

_____

<NAME>