OLMSTED MEDICAL CENTER

Healthcare Directive
(Abbreviated Version)

Full Name: _____ DOB: _____ Patient ID#: _____
(first, middle, last) (if known)

I, _____, understand this document allows me to do **one or both** of the following:

Part I: Name another person (called the healthcare agent) to make healthcare decisions for me if I am unable to decide or speak for myself. My healthcare agent must make healthcare decisions, if any, for me based on the instructions I provide in this document (Part II), the wishes I have made known to him or her, or in my best interest if I have not made my healthcare wishes known.

and/or

Part II: Give healthcare instructions to guide others making healthcare decisions for me. If I have named a healthcare agent, these instructions are to be used by the agent. These instructions may also be used by my healthcare providers, others assisting with my healthcare, and my family, in the event I cannot make decisions for myself.

Part I

Primary Healthcare Agent
This is who I want to make healthcare decisions for me if I am unable to decide or speak for myself.

Name: _____

Relationship: _____

Telephone number(s): _____

Address: _____

_____

Optional Healthcare Agent
If my healthcare agent is not reasonably available to serve, I trust and appoint:

Name: _____

Relationship: _____

Telephone number(s): _____

Address: _____

_____

Part II

This is what I want my healthcare agent to be able to do if I am unable to decide, in the determination of my attending physician, or speak for myself.

My healthcare agent has the power to:

(A) Make any healthcare decisions for me. This includes the power to give, refuse, or withdraw consent to any care, treatment, service, or procedures. This includes deciding whether to stop or not start healthcare that is keeping me or might keep me alive and deciding about intrusive mental health treatment.

(B) Choose my healthcare providers.

(C) Choose where I live and receive care and support when those choices relate to my healthcare needs.

(D) Receive, review, obtain copies of, and consent to the disclosure of my medical records.

My healthcare agent must follow my healthcare instructions in this document or any other instructions I have given to my agent. If I have not given healthcare instructions, then my agent has a duty to act in good faith and in my best interest.

Healthcare Directive – Abbreviated Version

Healthcare Instructions (values, preferences, guidelines, or directions regarding healthcare) stated here:

Part III: Making The Document Legal

This document must be signed by me. It also must either be verified by a notary public (Option 1) **or** witnessed by two witnesses (Option 2). It must be dated when it is verified or witnessed.

I am thinking clearly, I agree with everything that is written in this document, and I have made this document willingly.

My Signature: _____ Date: _____ DOB: _____

Address: _____

If I cannot sign my name, I can ask someone to sign this document for me.

_____ _____

Signature of the person I asked to sign this document for me

Printed name of the person who I asked to sign this document for me (if known)

Option 1: Notary Public

In my presence on _____ day of _____, 20____, _____ (name) acknowledged his/her signature on this document or acknowledge that he/she authorized the person signing this document to sign on his/her behalf. I am not named as a healthcare agent or alternate healthcare agent in this document.

_____

Notary Public Signature

Option 2: Two Witnesses

Two witnesses must sign. Only one of the two witnesses can be a healthcare provider or an employee of a healthcare provider giving direct care to me on the day I sign this document.

Witness One:

(i) In my presence on _____(date), _____ (name) acknowledged his/her signature on this document or acknowledged that he/she authorized the person signing this document to sign on his/her behalf.
(ii) I am at least 18 years of age.
(iii) I am not named as a healthcare agent or an alternate healthcare agent in this document.
(iv) If I am a healthcare provider or an employee of a healthcare provider giving direct care to the person listed above, I must initial this box: [ ]

I certify that the information in (i) through (iv) is true and correct.

Signature of Witness One: _____

Address: _____

Witness Two:

(i) In my presence on _____(date), _____ (name) acknowledged his/her signature on this document or acknowledged that he/she authorized the person signing this document to sign on his/her behalf.
(ii) I am at least 18 years of age.
(iii) I am not named as a healthcare agent or an alternate healthcare agent in this document.
(iv) If I am a healthcare provider or an employee of a healthcare provider giving direct care to the person listed above, I must initial this box: [ ]

I certify that the information in (i) through (iv) is true and correct.

Signature of Witness Two: _____

Address: _____

REMINDER: Keep this **original** document with your personal papers in a safe place (not in a safe deposit box). Give signed **copies** to your healthcare providers, family, close friends, healthcare agent, and alternate healthcare agent. Make sure your healthcare provider is willing to follow your wishes. This document should be part of your medical record at your healthcare provider's office and at the hospital, home care agency, hospice, or nursing facility where you receive care.