**Form 1-3: Advance Medical Directive**

[[Text Box Start]]

Appoints Coagents to serve jointly or independently with a Substitute

Removal of life-sustaining procedures

Continue with nutrition and hydration

[[Text Box End]]

**Advance Medical Directive**

**I. Appointment of Health Care Agents**

**A. Designation of Health Care Agents**

I, (*insert name of Declarant*), presently residing in (*insert county/city*), State of Maryland, hereby appoint (*insert relationship*), (*insert name of Co-agent*) and (*insert relationship*), (*insert name of Co- agent*) as my Agents jointly or independently, to make health care decisions for me as authorized in this document. If (*insert relationship*), (*insert name of Co-agent*) or (*insert relationship*), (*insert name of Co-agent*), is unable to serve, then I appoint (*insert relationship*), (*insert name of Substitute Agent*), to serve in that capacity.

**B. Creation and Effectiveness**

My Agents' authority becomes operative when and if my treating physician certifies that I am disabled because I am incapable of making an informed decision regarding my own health care. The power shall continue in effect during my disability.

**C. General Statement of Authority Granted**

I hereby grant to my Agents named above full power and authority to make health care decisions on my behalf; including the following:

1. To request, review, and receive any information, oral or written, regarding my physical or mental health, including but not limited to, medical and hospital records, and to consent to the disclosure of this information;

2. To employ and/or discharge my health care providers;

3. To consent to and authorize my admission to or discharge from (including transfer to another facility) any hospital, hospice, nursing home, adult home, or other medical care facility;

4. To consent to the provision, withholding, or withdrawal of health care, including, in appropriate circumstances, life-sustaining procedures;

5. To make health care decisions for me based on the health care instructions I give in this document and on my wishes as otherwise known to my Agents. If my wishes are unknown or unclear, my Agents are to make health care decisions for me in accordance with my best interest, to be determined by my Agents after considering the benefits, burdens, and risks that might result from a given treatment or course of treatment, or from the withholding or withdrawal of a treatment or course of treatment;

6. To take any lawful actions that may be necessary to carry out these decisions, including the granting of releases of liability to medical providers; and

7. HIPAA Release Authority: I intend for my Agents to 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, 42 USC 1320d and 45 CFR 160-164 and future laws as amended from time to time. My Agents may sign as my Representative under the HIPAA Act any release forms or other HIPAA-related materials.

I authorize any physician, health-care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy, or other covered health care provider, any insurance company and the Medical Information Bureau, Inc. or any 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 Agents and health providers, 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 and treatment of HIV/AIDS, sexually transmitted diseases, mental illness, and drug or alcohol abuse.

The authority given to my Agents shall supersede any prior 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 to my Agents 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 providers. My Agents shall not be liable for the costs of care based solely on this authorization.

8. My Agents are authorized and directed to initiate litigation against any health care provider, hospital or family member who fails to promptly implement my Agents' directives.

9. My estate is directed to refuse and will not be responsible for payment of medical bills for any services that arise out of care that is inconsistent with my desires as expressed by my Agents.

10. I authorize my Agents to establish a new residence or domicile for me from time to time and at any time within or without Maryland and within or without the United States.

11. My Agents and my Agents' estate, heirs, successors and assigns are hereby released and forever discharged by me, my estate, my heirs and assigns from all liability and from all claims or demands of all kinds arising out of the acts or omissions of my Agents except for willful misconduct or gross negligence.

**II. Health Care Instruction**

If I am incapable of making an informed decision regarding my health care, I direct my health care providers to follow my instructions as set forth below:

**A. Terminal Condition is Imminent**

If my death from a terminal condition is imminent and even if life-sustaining procedure are used there is no reasonable expectation of my recovery, I direct that my life not be extended by life-sustaining procedures, except that if I am unable to take food by mouth**, I wish to receive nutrition and hydration artificially.**

**B. Persistent Vegetative State**

If I am in a persistent vegetative state, that is, if I am not conscious and am not aware of my environment or able to interact with others, and there is no reasonable expectation of my recovery, I direct that my life not be extended by life-sustaining procedures, except that if I am unable to take food by mouth, **I wish to receive nutrition and hydration artificially**.

**C. End-Stage Condition**

If I have an end-stage condition, that is a condition caused by injury, disease, or illness, as a result of which I have suffered severe and permanent deterioration, indicated by incompetency and complete physical dependency and for which, to a reasonable degree of medical certainty, treatment of the irreversible condition would be medically ineffective, I direct that my life not be extended by life-sustaining procedures, except that if I am unable to take food by mouth, **I wish to receive nutrition and hydration artificially**.

**D. Pain Medication**

I direct that no matter what my condition, medication be given to me to relieve pain and suffering, even if it would shorten my remaining life.

**E. All Available Medical Treatment**

I direct that no matter what my condition, I NOT be given all available medical treatment, in accordance with accepted health care standards.

**F. Photocopies**

I specifically authorize the use of a photocopy of this Advance Medical Directive instead of the original document in order to give effect to its terms and conditions.

**G. Signature of Declarant**

By signing below, I indicate that I am emotionally and mentally competent to make this advance directive and that I understand the purpose and effect of this document.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date  (*insert name of Declaran*t)

**H. Signature of Witnesses**

The declarant signed or acknowledged signing this appointment of health care agents in my presence and based upon my personal observation appears to be a competent individual.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date