Honoring Your Wishes™
A COMMUNITY-WIDE ADVANCE CARE PLANNING INITIATIVE

Health Care Directive

Overview

Adults with decision-making capacity have the right to make choices about their health care. No treatments may be given to someone who does not want them.

The attached Durable Power of Attorney for Health Care form is a legal health care directive. It meets the requirements of Iowa Code Chapter 144B. It allows you to choose a person and an alternate person to make your health care decisions for you if you are too sick to make them yourself. The person you ask to make health care choices for you is your **Health Care Agent.**

This form gives your agent the authority to make health care decisions for you only if:

- **You cannot communicate your wishes and health care decisions due to illness or injury, and**
- **Health care providers have determined you are not able to make your own health care decisions.**

This form does not give your agent permission to make your financial or other business decisions. As stated by Iowa law, "health care" means any care, treatment, service, or procedures to maintain, diagnose, or treat your physical or mental condition.

Take the time to read this form carefully before you fill it out. In this form, you can list the types of health care you do and do not want. You can limit the types of choices your health care agent can make. It is very important to talk about your views, values, and this form with your Health Care Agent. If you do not closely involve your agent, your views and values may not be fully respected because they may not be understood.

What if I decide not to complete a Durable Power of Attorney for Health Care form?

You do not have to sign a Durable Power of Attorney for Health Care form. Doctors, insurance providers, or hospitals cannot force you to have this type of form to receive their services. Under Iowa Code Chapter 144B, your life insurance cannot be canceled if your health care is being withdrawn or withheld according to your wishes in this form.

While you have a choice not to fill out this form, you should know that others may have to make health care decisions for you at some point in the future. Without telling someone your wishes, it may be hard for them to decide what you would want. Filling out this form can help you talk to your circle of support about what is important to you and can help them make decisions that match your goals and values.

What if I decide to cancel my Durable Power of Attorney for Health Care form?

You have the right to cancel your Durable Power of Attorney for Health Care form at any time. You can do this by telling your Health Care Agent or anyone else at any time and in any way. You should tell your health care provider, too. Also, let anyone else know who may have received a copy. Your current and valid form will cancel out any older versions.

If your spouse is your health care agent, and you get divorced, the power granted to your spouse by this form is revoked. If you would remarry your spouse, this power is reinstated unless you cancel it.

Initials ________
Date ________

Who should I choose to be my Health Care Agent?

A family member or friend who:

- Is at least 18 years old
- Knows you well
- Can be there for you when you need them
- Is willing to learn about your goals and values for health care decisions
- You trust will do what is best for you, and will follow your wishes
- Can make decisions under sometimes stressful situations

What kind of choices can my Health Care Agent make?

Your agent can decide:

- Which doctors, nurses, social workers or other health care team members may provide you care
- Which hospitals or clinics will treat your conditions
- The types of medicines, immunizations/vaccinations, tests, or treatments you get

What do I do with the form after I fill it out?

When you have completed your health care directive, you should:

- Tell the person you named as your Health Care Agent if you have not done so. Make sure the person feels able to do this important job for you in the future.
- Make copies:
  - ☐ 1 copy for yourself
  - ☐ 1 copy for your Health Care Agent and any alternates
  - ☐ 1 copy to share and talk about with your doctor or other health care providers
  - ☐ 1 copy for the hospital where you have been treated or would go in an emergency
  - ☐ extra copies to share with others (friends, family, clergy, attorney)

A copy of this form is as legally valid as the original.

Copies of this form will be given or have been given to:

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____

Initials ________
Date ________

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Durable Power of Attorney for Health Care Decisions

I, ____, (date of birth) ____________________,

select as my **Health Care Agent**:

Name: ____

Home:________________ Cell: __________________________Work______________________

Address: ____

I give to my agent the power to make health care decisions for me. This power exists only when I am not able, in the judgment of my health care provider, to make my own health care decisions. My Health Care Agent must act consistently with my desires as stated in this form or otherwise made known.

If the first person cannot be my Health Care Agent, I then select as my **alternate Health Care Agent:**

Name: ____

Home:___________________ Cell: _____________________ Work: ______________________

Address: ____

I understand my Health Care Agent:

- Will make choices for me **only** after I cannot make them myself in the judgment of my health care provider.
- Can tell my health care provider to stop giving me health care, even if it is needed to keep me alive.
- Can make decisions about all aspects of my care including but not limited to immunizations and vaccinations.
- Can choose my health care providers, including hospitals, doctors, and end-of-life care.
- Can look at my medical records and share my health care information as permitted (see page 2).
- Can sign releases or other forms about my medical treatment.
- Can decide if I should join a research study.

I now cancel all prior Durable Powers Of Attorney for Health Care Decisions.

Initials _____
Date _____

Consent for My Health Care Agent to Act as My Personal Representative and Consent for Release of Protected Health Information

I authorize my Health Care Agent to act as my personal representative for purposes of the Health Insurance Portability and Accountability Act (HIPAA) of 1996. This includes amendments to HIPAA during any time that my Health Care Agent is acting on my behalf.

I give my Health Care Agent permission to ask for, receive, or look at any information about my physical or mental health. I approve that any health care provider, health plan, hospital, clinic, laboratory, pharmacy, insurance company, or other health care related business can share my personal health information and medical records with my Health Care Agent. This includes any past, present or future medical or mental illness regarding my ability to make health care choices. This permission includes information protected by HIPAA.

I understand my Health Care Agent can sign authorizations, releases, or other records that may be needed to get this information. My Health Care Agent can also consent for the release of my information to others. I understand that my Health Care Agent may share this information with others. This means that my information is no longer protected by HIPAA.

I also have the right to look at any information shared with my Health Care Agent.

I will mark with my initials the information that my Health Care Agent **cannot** have access to:

_____ Alcohol, drug, and other substance abuse

_____ Behavioral and mental health

_____ Sexually transmitted diseases, AIDS, and HIV-related information

_____ Genetic tests

I understand my Health Care Agent's access to my personal health information by this document ends when I die. I can cancel this permission and consent at any time by telling my health care provider.

X______________________________________ ___________/_______/_____________
Sign your name Date

____
Print your name

Initials _____
Date _____

List of Desires, Special Provisions, or Limits

Sections A through F are specific instructions for my Health Care Agent and/or health care provider and team providing my health care. If I need treatment in a state that does not accept this Durable Power of Attorney for Health Care, or my Health Care Agent cannot be contacted, I want these instructions to be followed based on common law and my legal right to direct my health care.

Instructions for Filling in This Part

You do not have to give any written instructions or make any selections in this section. If you choose not to give any instructions, your Health Care Agent will make choices based on:

- Your verbal instructions
- What is felt to be in your best interest

If you choose not to give any instructions, draw a line and write “no instructions” across the page or section.

A. People Who My Health Care Agent Should Include in Decision-Making Steps

I ask that my Health Care Agent make an effort to include these people in my health care decisions:

____

____

B. Religion / Faith

(Write your initials and fill in the sections to help meet your wishes)

____I am of the ____ faith.

____I ask that my Health Care Agent or health care team call my faith-based group. The name and phone number of my faith community are:

____

____My specific religious or spiritual requests are:

____

____

____

____ I am non-religious.

Initials _____
Date _____

C. My Wishes

I understand that I will receive care to keep me as comfortable as possible. I will be offered pain medicine. I will be offered food and fluids by mouth if I am able to swallow.

1. I also have these requests for my health care team:

____

____

____

2. If possible, I would like the following for comfort and support (rituals, music, visitors, etc.):

____

____

____

3. The things that make life most worth living to me are:

____

____

____

4. My beliefs about when life would no longer be worth living:

____

____

____

5. My thoughts and feelings about where I would like to die:

____

____

____

6. A message to my family and friends:

____

____

____

____

Initials _____
Date _____

D. Stopping Treatments to Prolong My Life If I Have a Severe Permanent Brain Injury

If I reach a point where I can no longer make decisions for myself and it is reasonably certain that I will not recover my ability to know who I am or where I am (Write your initials on the line if you agree):

____ I want to **stop or withhold all treatments that are prolonging my life**. This includes but is not limited to tube feedings, IV (intravenous) fluids and medications, respirator/ventilator (breathing machine), dialysis, blood products, and antibiotics.

E. Cardiopulmonary Resuscitation (CPR)

CPR is a treatment used to try to restart a person's heart rhythm and breathing when they have stopped. It may involve:

- chest compressions (pushing hard on your chest to keep your blood pumping)
- medicines in your veins
- electrical shocks
- a breathing tube

I understand that CPR can save a life. I also understand that it does not work as well for people who have chronic (long-term) health problems and/or an illness that can no longer be treated.

My CPR choice listed below may be reconsidered by my Health Care Agent in light of my other instructions or new medical information. My Health Care Agent may act on my behalf if I cannot make my own choices.

If I do not want CPR tried, my health care provider should be told about my choice. If I show below that I do not want CPR, I understand this choice alone will not stop emergency workers from attempting CPR in an emergency. Other papers may be needed to control the actions of emergency workers.

Choose one option. Mark with your initials.

____ **I want CPR** tried.

____ **I want CPR** tried unless my health care provider decides any one of the following:

- I have an untreatable illness or injury and am dying, **or**
- I have little chance of surviving, **or**
- CPR would harm me more than help me.

____**I do not want CPR** tried. Rather, I want to allow a natural death.

Initials _____
Date _____

F. After I Die

(Write your initials and fill in the section that meets your wishes)

Organ Donation:

____ **I want** to donate my organs, tissues, and eyes if able. My specific wishes (if any) are:

____

____

____ I am registered with the Iowa Donor Network.

____ My driver's license is marked "Y" for "yes".

____ **I do not want** to donate my organs, tissues or eyes.

Body Donation:

A **different** option is to donate your body. These arrangements must be made **before** your death. If you wish to donate your body after death to medical science, please call a school listed below:

- University of Iowa Carver College Of Medicine
  Department of Anatomy and Cell Biology (319) 335-7762

- Des Moines University Body Donor Program
  Department of Anatomy (515) 271-1481

____ I have registered my body to be donated to ___________________________________

Initials _____
Date _____

How to Make This a Legal Document

In order for this form to be valid, it must be acknowledged or witnessed in **one** of the following ways:

- It must be signed by you in the presence of a notary public in Iowa.

  OR

- It must be signed by two witnesses. You and your two witnesses must all be present when the document is signed.

If you choose to use witnesses, they must:

- Be at least 18 years old
- Watch you sign this form
- Watch the other witness sign this form

Your witnesses cannot:

- Be your Health Care Agent or alternate health care agent
- Be your health care provider attending to you on the date this form is signed
- Work for your health care provider

Also, one witness cannot:

- Be related to you by blood, marriage, or adoption

Sign your name at the X and write the date below:

X ____ ____________/________/______________

Sign your name (or have designee sign your name) Date

____

Print your name (or have designee print your name)

____

Address City State Zip Code

If you are physically not able to sign this form, you can ask another person to sign it for you in your presence **and** in the presence of a notary or witnesses.

I cannot sign my name because:

____

If I cannot sign my name, I ask the following person (your designee) to sign for me (print name):

____

Signature (of person asked to sign):

____

Initials _____

Date _____

Notary Public

State of ___________________) County of _________________)

This form was acknowledged before me on ____ (date)

by ______________________________________ ____.
Name of Person or Name of Designee

____
Signature of Notary Public

Seal/Stamp

OR

Statement of Witnesses

By signing, I affirm that ____
Name of Person

and the other witness listed, signed this form (either personally or by designee) while I watched. I also affirm that:

- I know them or they could prove who they are
- I am 18 years or older
- I am not their Health Care Agent or alternate Health Care Agent
- I am not their health care provider
- I do not work for their health care provider

One witness must also affirm that:

- I am not related to them by blood, marriage, or adoption

Witness #1 (Sign your name at the X and write the date below):

X ____ _____________/________/_______________
Sign your name Date

____
Print your name

____
Address City State Zip Code

Witness #2 (Sign your name at the X and write the date below):

X ____ _____________/________/_______________
Sign your name Date

____
Print your name

____
Address City State Zip Code

Initials _____
Date _____