

**ADVANCE HEALTH CARE DIRECTIVE**  
(California Probate Code Section 4701)

Explanation

You have the right to give instructions about your own health care. You also have the right to name someone else to make health care decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding donation of organs and the designation of your primary physician. If you use this form, you may complete or modify all or any part of it. You are free to use a different form.

Part 1 of this form is a power of attorney for health care. Part 1 lets you name another individual as agent to make health care decisions for you if you become incapable of making your own decisions or if you want someone else to make those decisions for you now even though you are still capable. You may also name an alternate agent to act for you if your first choice is not willing, able, or reasonably available to make decisions for you. (Your agent may not be an operator or employee of a community care facility or a residential care facility where you are receiving care, or your supervising health care provider or employee of the health care institution where you are receiving care, unless your agent is related to you or is a co-worker.)

Unless the form you sign limits the authority of your agent, your agent may make all health care decisions for you. This form has a place for you to limit the authority of your agent. You need not limit the authority of your agent if you wish to rely on your agent for all health care decisions that may have to be made. If you choose not to limit the authority of your agent, your agent will have the right to:

- (a) Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition.
- (b) Select or discharge health care providers and institutions.
- (c) Approve or disapprove diagnostic tests, surgical procedures, and programs of medication.
- (d) Direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care, including cardiopulmonary resuscitation.
- (e) Make anatomical gifts, authorize an autopsy, and direct disposition of remains.

Part 2 of this form lets you give specific instructions about any aspect of your health care, whether or not you appoint an agent. Choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive, as well as the provision of pain relief. Space is also provided for you to add to the choices you have made or for you to write out any additional wishes. If you are satisfied to allow your agent to determine what is best for you in making end-of-life decisions, you need not fill out Part 2 of this form.

Part 3 of this form lets you express an intention to donate your bodily organs and tissues following your death.

Part 4 of this form lets you designate a physician to have primary responsibility for your health care.

After completing this form, sign and date the form at the end. The form must be signed by two qualified witnesses or acknowledged before a notary public. Give a copy of the signed and completed form to your physician, to any other health care providers you may have, to any health care institution at which you are receiving care, and to any health care agents you have named. You should talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take the responsibility.

You have the right to revoke this advance health care directive or replace this form at any time.

## PART 1 POWER OF ATTORNEY FOR HEALTH CARE

(1.1) **DESIGNATION OF AGENT:** **[Primary Agent]:** I designate the following individual as my agent to make health care decisions for me:

The Prince, The Castle, (213) 413-4134

[insert name, address, and telephone number of one individual as your agent to make health care decisions for you].

**[First Alternate Agent]:** If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health care decision for me, I designate as my first alternate agent:

The Huntsman, Hunter's Lodge Behind the Castle, (213) 413-3214

[insert name, address, and telephone number of one individual as your first alternate agent].

**[Second Alternate Agent]:** If I revoke the authority of my agent and first alternate agent or if neither is willing, able, or reasonably available to make a health care decision for me, I designate as my second alternate agent:

[insert name, address, and telephone number of one individual as your second alternate agent].

(1.2) **AGENT'S AUTHORITY:** My agent is authorized to make all health care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care to keep me alive, except as I state here:

(1.3) **WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE:** My agent's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions unless I mark the following box. If I mark this box , my agent's authority to make health care decisions for me takes effect immediately.

(1.4) **AGENT'S OBLIGATION:** My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

(1.5) **AGENT'S POSTDEATH AUTHORITY:** My agent is authorized to make anatomical gifts, authorize an autopsy, and direct disposition of my remains, except as I state here or in Part 3 of this form:

(1.6) **NOMINATION OF CONSERVATOR:** If a conservator of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able, or reasonably available to act as conservator, I nominate the alternate agents whom I have named, in the order designated.

## PART 2 INSTRUCTIONS FOR HEALTH CARE

(2.1) **END-OF-LIFE DECISIONS:** I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below:

(a) Choice Not To Prolong Life

I do not want my life to be prolonged if (1) I have an incurable and irreversible condition that will result in my death within a relatively short time, (2) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (3) the likely risks and burdens of treatment would outweigh the expected benefits, OR

(b) Choice To Prolong Life

I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

(2.2) **RELIEF FROM PAIN:** Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death:

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(2.3) **OTHER WISHES:** [If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.] I direct that:

*I am allergic to apples and apple-based products.*

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### PART 3 DONATION OF ORGANS AT DEATH (OPTIONAL)

(3.1) Upon my death [mark applicable box]:

(a) I give any needed organs, tissues, or parts, OR

(b) I give the following organs, tissues, or parts only:

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(c) My gift is for the following purposes [strike any of the following you do not want]:

(1) Transplant

(2) Therapy

(3) Research

(4) Education

### PART 4 PRIMARY PHYSICIAN (OPTIONAL)

(4.1) I designate the following physician as my primary physician:

*Doc, The Mysterious Cottage in the Forest, (213) 413-2314*

[insert name, address, and telephone number of physician].

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OPTIONAL: If the physician I have designated above is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician:

[insert name, address, and telephone number of alternate physician].

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### PART 5

(5.1) **EFFECT OF COPY:** A copy of this form has the same effect as the original.

(5.2) **SIGNATURE:** Sign and date the form here:

*January 21, 2020*

Date

*SNOW WHITE*

Signature

*Snow White*

Printed name

*The Castle*

Address

Address

(5.3) **STATEMENT OF WITNESSES:** I declare under penalty of perjury under the laws of California (1) that the individual who signed or acknowledged this advance health care directive is personally known to me, or that the individual's identity was proven to me by convincing evidence, (2) that the individual signed or acknowledged this advance directive in my presence, (3) that the individual appears to be of sound mind and under no duress, fraud, or undue influence, (4) that I am not a person appointed as agent by this advance directive, and (5) that I am not the individual's health care provider, an employee of the individual's health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility for the elderly, nor an employee of an operator of a residential care facility for the elderly.

January 21, 2020

\_\_\_\_\_  
Date

**First witness**

**Second witness**

MW  
\_\_\_\_\_  
Signature

Katharina  
\_\_\_\_\_  
Signature

Margaretha von Waldeck  
\_\_\_\_\_  
Printed name

Katharina of Hatzfeld  
\_\_\_\_\_  
Printed name

123 Main Street  
\_\_\_\_\_  
Address

345 First Street  
\_\_\_\_\_  
Address

Los Angeles, CA 90012  
\_\_\_\_\_  
Address

Los Angeles, CA 90012  
\_\_\_\_\_  
Address

(5.4) **ADDITIONAL STATEMENT OF WITNESSES:** At least one of the above witnesses must also sign the following declaration:

I further declare under penalty of perjury under the laws of California that I am not related to the individual executing this advance health care directive by blood, marriage, or adoption, and to the best of my knowledge, I am not entitled to any part of the individual's estate upon his or her death under a will now existing or by operation of law

Katharina of Hatzfeld  
\_\_\_\_\_  
Printed name of witness

Katharina  
\_\_\_\_\_  
Signature

**PART 6 SPECIAL WITNESS REQUIREMENT**

(6.1) The following statement is required only if you are a patient in a skilled nursing facility—a health care facility that provides the following basic services: skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis. The patient advocate or ombudsman must sign the following statement:

**STATEMENT OF PATIENT ADVOCATE OR OMBUDSMAN**

I declare under penalty of perjury under the laws of California that I am a patient advocate or ombudsman as designated by the State Department of Aging and that I am serving as a witness as required by Section 4675 of the Probate Code.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Printed name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Address

**VALID AUTHORIZATION UNDER HIPAA AND CMIA**

The federal and state governments have recently enacted legislation designed to protect the privacy of patients' medical information. These acts are known as the Health Insurance Portability Act of 1996 (HIPAA) (Pub L 104-191, 110 Stat 1936) and the Confidentiality of Medical Information Act (CMIA) (CC Sections 56-56.37). The undersigned hereby authorizes disclosure of individually identifiable health information as follows:

(1) **DESCRIPTION OF INFORMATION TO BE USED OR DISCLOSED.** All medical information deemed relevant by my attending physicians to the conditions that I am experiencing from time to time.

(2) **IDENTIFICATION OF PERSONS AUTHORIZED TO MAKE THE USE OR DISCLOSURE.** All hospitals, diagnostic centers, laboratories, pharmacists, insurance companies, doctors' offices and medical personnel who have treated me for the conditions that I am experiencing from time to time.

(3) **IDENTIFICATION OF PERSON TO WHOM THE COVERED ENTITY MAY MAKE THE REQUESTED USE OR DISCLOSURE.** The disclosures may be made to my **Health Care Agent(s)** and my attending physicians. My **Health Care Agent(s)** and my attending physicians may use the information for my care and treatment and for obtaining health insurance coverage therefor.

(4) **EXPIRATION DATE OR EVENT.** This Authorization shall expire when my estate has been finally settled for federal estate tax purposes.

(5) **COPY.** The undersigned Principal has the right to receive a copy of this Valid Authorization Under HIPAA and CMIA.

I have signed this Valid Authorization Under HIPAA and CMIA on January 21, 2020 at Los Angeles, California.

*SNOW WHITE*

\_\_\_\_\_  
Signature

*Snow White*

\_\_\_\_\_  
Printed name

*The Castle*

\_\_\_\_\_  
Address

\_\_\_\_\_  
Address