Instructions for completing your Advance Healthcare Directive

Read the document carefully

Read through your document entirely and make sure you understand everything. If there's anything you feel like you don't understand, be sure to speak with an attorney.

Execute the document

- Find 2 witnesses OR a notary public.
- If you choose to execute your documents using witnesses, your witnesses should fulfill the following criteria *(Note: depending on your state, the rules for prohibited witnesses may be less restrictive than what is written below. If you are familiar with the execution formalities for advance healthcare directives in your state, feel free to follow them instead):*
    - Must be older than 18;
    - Cannot be related to you by blood, marriage or adoption;
    - Cannot be entitled to any portion of your estate;
    - Cannot have been named as an agent, co-agent or successor agent in the advance healthcare directive;
    - Cannot be related by blood, marriage or adoption to someone named as an agent, co-agent or successor agent in the advance healthcare directive;
    - Cannot be someone that is financially responsible for your healthcare;
    - Cannot be someone that provides you with healthcare services;
    - Cannot be the owner, operator, or employee of a healthcare facility or retirement home that you reside in;
    - Cannot be your life or health insurance provider;
    - Cannot be a spouse or employee of any of the above parties
- If you choose to execute your documents using witnesses, verbally acknowledge, in their presence, that this is your advance healthcare directive. For example, you could say, "This is my advance healthcare directive that I am signing and it represents my wishes for my healthcare if I become unable to make healthcare decisions for myself."
- Write your initials in each section within the designated boxes.

- Locate and complete the section titled “SIGNATURE.”
- Then, have all other parties sign in the appropriate areas.

Keep Safe & Distribute Copies

- Keep your original documents in a safe and accessible place, such as a fireproof box in your home.
- Discuss your wishes with your appointed agent, alternate agents, doctors, and loved ones. Often, disagreement about end-of-life medical care comes from those who care about you not knowing your wishes in advance.
- Make copies of your signed advance healthcare directive and distribute them to these parties.

Update

- It’s a good idea to update your documents every 3-5 years, especially if you marry, have children, divorce, move, or go through any other major life changes.
- If you need to adjust anything, destroy the original copy of your documents and make a new one. Do not attempt to amend your existing documents by adding, crossing out, or modifying text.
- Always be sure to destroy any of your old documents, including any duplicates and ones you’ve previously distributed.

HIPAA Agents

- If you chose to designate HIPAA Agents, note that their power will become effective as soon as you sign the HIPAA Release and Authorization document, which may be different than the effective date you chose for your healthcare agent(s).

Advance Healthcare Directive of
CYDNIE LACOLE MURPHY

DECLARATIONS

1.1. Declarations.

This is my Advance Healthcare Directive. I revoke all prior Advance Healthcare Directives.

My full legal name is CYDNIE LACOLE MURPHY.

I live at 723 Roanoke Ave, Memphis, TN 38106.

My date of birth is January 17, 1985.

POWER OF ATTORNEY FOR HEALTHCARE

2.1. Healthcare Agent.

If I am unable to communicate my wishes and healthcare decision, or if my healthcare provider has determined that I am not able to make my own healthcare decisions, I nominate the individual named below as my primary healthcare agent:

Name: RICKY MURPHY
Email: MURPHY.RICKY1239@GMAIL.COM
Address: 723 ROANOKE AVENUE, MEMPHIS, TN 38106
Phone: (502) 309-4806
Primary relationship to me: HUSBAND

Initial: ☐

If I cancel my primary healthcare agent's authority, or if my primary agent is not willing, able, or reasonably available to make a healthcare decisions for me, I nominate the individual named below as my first alternate healthcare agent:

Name: PHILLIP GREGORY
Email: CYDNIET@GMAIL.COM
Address: 123 MAIN ST, JEFFERSONVILLE , IN 47130
Phone: (812) 555-1234
Primary relationship to me: BROTHER

Initial: ☐

2.2. When Healthcare Agent's Authority Becomes Effective. My healthcare agent's authority becomes effective only after my doctor determines I cannot make my own decisions.

Initial: ☐

2.3. HIPAA Release Authority. My healthcare agent shall have the power to exercise all of my rights and privileges that are granted to me under federal and state law (including the Health Insurance Portability and Accountability Act of 1996 ("HIPAA")), concerning the confidentiality, use, and disclosure of my confidential medical information, including the right to obtain copies of any such confidential medical information.

Initial: ☐

2.4. Limits or Expansion of Healthcare Agent's Authority.

If I am diagnosed as pregnant and am unable to speak for myself, I revoke my healthcare agent's authority to make decisions for me, and direct my doctors to treat me in accordance with my wishes set forth in this directive.

I wish to limit or expand the powers of my health care agent as follows:

_____

_____

_____

Initial: ☐

MY VALUES AND WISHES

3.1. Values.

My life is only worth living if I can: talk to family or friends, wake up from a coma, feed, bathe, or take care of myself, live without being hooked up to machines.

What matters most to me is: FAMILY.

If I were having a good day, I would be doing the following: BE AT A FAMILY FUNCTION HANGING OUT WITH MY COUSINS.

My doctors should know the following about my religious or spiritual beliefs:

_____

_____

_____

Initial: ☐

3.2. Healthcare Wishes.

If the likely risks and burdens of treatment would outweigh the expected benefits, or if I become unconscious and, to a realistic degree of medical certainty, I will not regain consciousness, or if I have an incurable and irreversible condition that will result in my death in a relatively short time, I want my life prolonged as long as possible within the limits of generally accepted healthcare standards until my agent decides it is time to stop.

I want to receive my care at home.

If I am diagnosed as pregnant and am unable to speak for myself, I direct that life-sustaining treatment be provided to me so long as it is probable that the fetus will develop to be viable outside the uterus with the continued application of life-sustaining treatment.

I would not like to give any of my organs, tissues, or parts upon my death.

I give my agent the power to authorize an autopsy to be done.

I also have the following wishes:

_____

_____

_____

Initial: ☐

3.3. Preferred Physician.

My preferred primary physician is named below:

Name: MELANIE WOODALL
Address: 4625 POPLAR AVE , MEMPHIS, TN 38117

Initial: ☐

3.4. Preferred Hospital.

I have not declared a preferred hospital.

Initial: ☐

SIGNATURE

These requests, appointments, and designations are made after careful reflection, while I am of sound mind. I sign my name to this Advance Healthcare Directive at _____ *(City)* in the State of Tennessee.

SIGNATURE OF PRINCIPAL DATE

(THIS ADVANCE DIRECTIVE MUST BE SIGNED BY TWO WITNESSES OR A NOTARY PUBLIC)

STATEMENT OF WITNESSES

Each of us declares under penalty of perjury under the laws of State of Tennessee that the following is true and correct:

1. On the date written below the maker of this Advance Healthcare Directive declared to us that this instrument was the maker's Advance Healthcare Directive and requested us to act as witnesses to it;
2. This Advance Healthcare Directive consists of 6 pages, including the witness signature page;
3. The maker signed this Advance Healthcare Directive in our presence, all of us being present at the same time;
4. We now, at the maker's request, and in the maker's and each other's presence, sign below as witnesses;
5. We believe the maker is of sound mind and memory;
6. We believe that this Advance Healthcare Directive was not procured by duress, menace, fraud or undue influence;
7. We believe the maker is age 18 or older;
8. Each of us is now age 18 or older, is a competent witness, and resides at the address set forth after his or her name; and
9. Each of us is not an individual appointed as an agent, the maker's healthcare provider, an employee of the maker's healthcare provider, financially responsible for the maker's healthcare,

an employee of the maker's life or health insurance provider, related to the maker by blood, marriage, or adoption, nor, to the best of our knowledge, a creditor of the person or entitled to any part of the maker's estate.

NAME OF FIRST WITNESS	NAME OF SECOND WITNESS
ADDRESS OF FIRST WITNESS	ADDRESS OF SECOND WITNESS
DATE	DATE
SIGNATURE OF FIRST WITNESS	SIGNATURE OF SECOND WITNESS

OR

ACKNOWLEDGMENT

STATE OF TENNESSEE)
) ss.
COUNTY OF _____)

On this _____ day of _____, 20____, personally appeared _____, known to me (or satisfactorily proven) to be the person(s) named in the foregoing instrument, appeared before me, a Notary Public, within and for the State and County aforesaid, and acknowledged that they freely and voluntarily executed the same for the purpose(s) and capacity(ies) stated therein.

(seal) Signature of Notary Public _____

Printed Name _____

Commission Expires _____

HIPAA RELEASE AND AUTHORIZATION
OF
CYDNIE LACOLE MURPHY

I, CYDNIE LACOLE MURPHY, hereby authorize the following persons (hereinafter collectively referred to as "agent") to act as my agents with regard to the matters specified in this Release:

RICKY LEWIS MURPHY,
_____ (address)

For purposes of this Release, the following persons shall also be treated as my agents in addition to the persons listed above: (i) any person designated as a primary or successor agent or proxy in a durable power of attorney or healthcare power of attorney or advance health care directive which I have executed, whether or not such person is presently serving as such; (ii) any person presently serving as trustee or named as a successor trustee in any revocable or irrevocable trust created by me as grantor or settlor; and (iii) any successor custodian I have named on a Uniform Transfers to Minors Account, Uniform Gifts to Minors Account, Section 529 Account, or other similar minor's account.

This Release and all the provisions contained herein are effective immediately. I intend for my agent to be treated as I would be treated with respect to my rights regarding the use and disclosure of my individually identifiable health information and other medical records. This Release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. Sections 1320d to 1320d-9 and 45 C.F.R. Sections 164.500 to 164.534, as may be amended from time to time.

AUTHORIZATION

I hereby authorize any doctor, physician, medical specialist, psychiatrist, chiropractor, health care professional, dentist, optometrist, health plan, hospital, hospice, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, pathologist, or other provider of medical or mental health care, as well as any insurance company and the Medical Information Bureau Inc. or other health care clearinghouse that has paid for or is seeking payment from me for such services (referred to herein as a "covered entity"), to give, disclose, and release to my agent who is named herein and who is currently serving as such and 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. Additionally, this disclosure shall include the ability to ask questions and discuss this protected health information with the person or entity who has possession of the

protected health information even if I am fully competent to ask questions and discuss this matter at the time. It is my intention to give a full authorization to access any protected health information to my agent. Health information and medical records as indicated above shall be released at my request or at the request of my agent named herein as may be needed to assist in my treatment, make decisions about my care or for any other reason, at my discretion or at the discretion of my agent.

In determining whether I am incapacitated, all individually identifiable health information and medical records shall be released to my agent, including any written opinion relating to my incapacity that my agent may have requested. This release authority applies to any information governed by HIPAA and applies even if my agent has not yet begun serving as my agent.

The authority given to my agent 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 individually identifiable health information and other medical records given, disclosed, or released to my agent may be subject to re-disclosure by my agent and may no longer be protected by HIPAA.

TERMINATION

This Release shall terminate on the first to occur of: (i) two years following my death, or (ii) my written revocation actually received by the covered entity. Proof of receipt of my written revocation may be by certified mail, registered mail, facsimile, electronic mail, or any other means evidencing actual receipt by the covered entity. This Release shall not be affected by my subsequent disability or incapacity. There are no exceptions to my right to revoke this Release.

RELEASE FROM LIABILITY

Each covered entity that acts in reliance on this Release shall be released from liability that may result from disclosing my individually identifiable health information and other medical records.

LEGAL ACTION

I authorize my agent to bring a legal action against a covered entity which refuses to accept and recognize this Release. No covered entity may condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization when the prohibition on conditioning of authorizations in 45 C.F.R. Section 164.508(b)(4) applies. Further, to fulfill my intent as expressed herein, I authorize my agent to sign any documentation that my agent deems necessary or appropriate to secure the disclosure of my individually identifiable health information and other medical records.

SUBSEQUENT DISCLOSURE OF INFORMATION

Any information disclosed to my agent under this Release may subsequently be disclosed to another party by my agent. My agent shall not be required to indemnify a covered entity or perform any act if information is subsequently disclosed by my agent.

COPIES AND FACSIMILES

Copies or facsimiles of this Release shall be as valid as the original Release.

SIGNATURE OF PRINCIPAL

I sign my name to this Release on _____, 20___, at

_____ County, Tennessee.

_____CYDNIE LACOLE MURPHY, Principal

ACKNOWLEDGMENT

STATE OF TENNESSEE)
) ss.
COUNTY OF _____)

On this _____ day of _____, 20____, personally appeared _____, known to me (or satisfactorily proven) to be the person(s) named in the foregoing instrument, appeared before me, a Notary Public, within and for the State and County aforesaid, and acknowledged that they freely and voluntarily executed the same for the purpose(s) and capacity(ies) stated therein.

(seal) Signature of Notary Public _____

Printed Name _____

Commission Expires _____