

NEW MEXICO

ADVANCE HEALTH CARE DIRECTIVE

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 the designation of your primary care practitioner.

THIS FORM IS OPTIONAL. Each paragraph and word of this form is also optional. If you use this form, you may cross out, complete or modify all or any part of it. You are free to use a different form. If you use this form, be sure to sign it and date it.

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. Unless related to you, your agent may not be an owner, operator or employee of a health-care institution at which you are receiving care.

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 practitioners and institutions;
- (c) approve or disapprove diagnostic tests, surgical procedures, programs of medication and orders not to resuscitate; and
- (d) direct the provision, withholding or withdrawal of artificial nutrition and hydration and all other forms of health care.

THIS FORM IS OPTIONAL. You do not have to use any form; instead, you may tell your doctor who you want to make health care decisions for you. If you have not signed a form or told your doctor who you want to make your health care decisions, New Mexico law allows these people, in the following order, to make your health care decisions (if these people are reasonably available): 1) spouse, 2) significant others, 3) adult child, 4) parent, 5) adult brother or sister, 6) grandparent, 7) close friend.

PART 2 of this form lets you give specific instructions about any aspect of your health care. Choices are provided for you to express your wishes regarding life-sustaining treatment, including the provision of artificial nutrition and hydration, as well as the provision of pain relief. In addition, you may express your wishes regarding whether you want to make an anatomical gift of some or all of your organs and tissue. Space is also provided for you to add to the choices you have made or for you to write out any additional wishes.

PART 3 of this form lets you designate a primary care practitioner to have primary responsibility for your health care.

After completing this form, sign and date the form at the end. It is recommended but not required that you either request two other individuals to sign as witnesses or acknowledge the form before a Notary Public. Give a copy of the signed and completed form to your physician, to any other health-care practitioners 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. DESIGNATION OF AGENT: I, **Test K3hijhui User**, of Test Adress 1 Parko City, New Mexico 74140, , designate my Mother jyhfg lkijyfg, of kjl,hgv ljyf ;lkugvl;oug, in new york, New York, 20145, (Tel: 0201456123), as my agent to make health care decisions for me.

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 my Husband lasfijyg lkjufayg, Of awsretg aserdfhg aewhesahrb, in new york, , Alabama, 20145. (Tel: 0201456123), as my alternate agent to make health care decisions for me as authorized in this document.

2. AGENT'S AUTHORITY: My agent is authorized to to obtain and review medical records, reports and information about me and make all health-care decisions for me, including decisions to provide, withhold or withdraw artificial nutrition, hydration and all other forms of health care to keep me alive, except as I state here:

(Add additional pages if needed)

My agent's power shall include the power to do the following: