Utah Advance Health Care Directive

(Pursuant to Utah Code Sections 75-2a-117, effective 2009)

Part I: ***Allows you to name another person to make health care decisions for you when you cannot make decisions or speak for yourself.***

Part II: ***Allows you to record your wishes about health care in writing.***

Part III: ***Tells you how to revoke or change this directive.***

Part IV: ***Makes your directive legal.***

My Personal Information

Name: **Test K3hijhui User ,**

Address: Test Adress 1

Address: Parko City Utah 20145,

Telephone: 2014561230,

Date of Birth: 2018-04-30,

Part I: My Agent (*Health Care Power of Attorney*)

A. No Agent:

(If you do not want to name an agent, initial the line below, then go to Part II; do not name an agent in B. or C. below. You are not required to name an agent, and no one can force you to name an agent)

_____ I do not want to choose an agent.

OR

B. My Agent. I want the following person to make health care decisions for me:

Name: jyhfg lkijyfg

Relation: Mother,

Phone #: 0201456123

Address: kjl,hgv ljyf ;lkugvl;oug,

new york, New York, 20145,

C. My Alternate Agent. If the person named above is unable or unwilling to make health care decisions for me, I appoint as alternate agent:

Name: lasfijyg lkjufayg

Relation: Husband,

Phone #: 0201456123,

Address: awsretg aserdfhg aewhesahrb,

new york, Alabama, 20145,

Name: _____

Relation: _____

Phone #: _____

Address: _____

END IF

D. My Agent's Authority. If I cannot make decisions or speak for myself (in other words, after my physician or another authorized provider finds that I lack health care decision making capacity under Section 75-2a-104 of the Advance Health Care Directive Act), my agent has the power to make any health care decision I could have made such as, but not limited to:

- Consent to, refuse, or withdraw any health care. This may include care to prolong my life such as food and fluids by tube, use of antibiotics, CPR (cardiopulmonary resuscitation), and dialysis, and mental health care, such as convulsive therapy and psychoactive medications. This authority is subject to any limits in paragraph F of Part I or in Part II of this directive.
- Hire and fire health care providers.
- Ask questions and get answers from health care providers.
- Consent to admission or transfer to a health care provider or health care facility, including a mental health facility, subject to any limits in paragraphs E or F of Part I.
- Get copies of my medical records.
- Ask for consultations or second opinions.

My agent cannot force health care against my will, even if a physician has found that I lack health care decision making capacity.

E. Other Authority.

My agent has the powers below ONLY IF I initial above “YES” option that precedes the statement. I authorize my agent to:

_____YES _____NO Get copies of my medical records at any time, even when I can speak for myself.

_____YES _____NO Admit me to a licensed health care facility, such as a hospital, nursing home, assisted living, or other facility for long-term placement other than convalescent or recuperative care.

F. Limits/Expansion of Authority. I wish to limit or expand the powers of my health care agent:

_____

_____

_____

(Attach additional sheets if needed.)

G. Nomination of Guardian:

(Even though appointing an agent should help you to avoid a guardianship, a guardianship may still be necessary. Initial above "YES" if you want the court to appoint your agent to serve as your guardian, if a guardianship is ever necessary)

_____YES _____NO I, being of sound mind and not acting under duress, fraud, or other undue influence, do hereby nominate my agent, or, if my agent is unable or unwilling to serve, I nominate my alternate agent to serve as my guardian in the event that, after the date of this instrument, I become incapacitated.

H. Consent to Participate in Medical Research:

_____YES _____NO I authorize my agent to consent to my participation in medical research or clinical trials, even if I will not benefit from the results.

I. Organ Donation:

_____YES _____NO If I have not otherwise agreed to organ donation, my agent may consent to the donation of my organs for the purpose of organ transplantation.

Part II: My Health Care Wishes (*Living Will*)

I want my health care providers to follow the instructions I give them when I am being treated, even if my instructions conflict with these or other advance directives. My health care providers should always provide health care to keep me as comfortable and functional as possible.

Choose only one *of the following options by placing your initials before the numbered statement. Do not initial more than one option. If you do not wish to document end-of-life wishes, initial Option 4. You may draw a line through the options that you are not choosing.*

OPTION 1

(INITIALS)

_____ I choose to let my agent decide. I have chosen my agent carefully. I have talked with my agent about my health care wishes. I trust my agent to make the health care decisions for me that I would make under the circumstances.

Additional comments: _____

_____

OPTION 2

_____ I choose to prolong life. Regardless of my condition or prognosis, I want my health care team to try to prolong my life as long as possible within the limits of generally accepted health care standards.

Additional comments: _____

_____

OPTION 3

_____ **I choose not to receive care for the purpose of prolonging life,** including food and fluids by tube, antibiotics, CPR, or dialysis being used to prolong my life. I always want comfort care and routine medical care that will keep me as comfortable and functional as possible, even if that care may prolong my life.

If you choose this option, you must also choose either (a) or (b), below.

_____ (a) I put no limit on the ability of my health care provider or agent to withdraw life-sustaining care.

Go to next page. Do not choose options below.

_____ (b) My health care provider should decline to provide life-sustaining care if at least one of the initialed conditions is met: ***You must initial at least one of the options below. You may choose more than one condition.***

_____ I have a progressive illness that will cause death

_____ I am close to death and I am unlikely to recover

_____ I cannot communicate and it is unlikely that my condition will improve

_____ I do not recognize my friends or family and it is unlikely that my condition will improve

_____ I am in a persistent vegetative state

Additional comments: _____

_____

OPTION 4

_____ I do not wish to express preferences about health care wishes in this directive.

Additional comments: _____

_____

Additional instructions about your health care wishes:

_____

_____

_____

_____

_____

(Add additional sheets if needed.)

Part III: Revoking or Changing a Directive

I may revoke or change this directive by:

1. Writing "void" across the form, burning, tearing, or otherwise destroying or defacing this document or directing another person to do the same on my behalf;

2. Signing a written revocation of the directive, or directing another person to sign a revocation on my behalf;

3. Stating that I wish to revoke in the presence of a witness age 18 years of age or older, who will not be appointed agent in a substitute directive and who will not become a default surrogate if the directive is revoked, and who signs and dates a written document confirming my statement; or

4. Drafting a new directive. **(*If you sign more than one Advance Health Care Directive, the most recent directive applies.)***

Part IV: Making the Document Legal

I sign this directive voluntarily. I understand the choices I have made, and declare that I am emotionally and mentally competent to make this directive. My signature on this form revokes any living will or power of attorney form naming a health care agent that I have completed in the past.

DATE: _____

_____

Test K3hijhui User

City, State, _____ County

I have witnessed the signing of this directive, I am 18 years of age or older, and:

1. I am not related to the declarant by blood or marriage;
2. I am not entitled to any portion of the declarant's estate according to the laws of intestate succession of this state or under any will or codicil of the declarant;
3. I am not the beneficiary of a life insurance policy, trust, qualified plan, property or accounts held in POD, TOD, or co-ownership registration with the right of survivorship;
4. I am not financially responsible for the declarant's support or medical care;
5. I am not a health care provider who is providing care to the declarant or an administrator at a health care facility in which the declarant is receiving care; and
6. I am not the appointed agent or alternate agent.

WITNESS 1: _____ Dated: _____

[signature]

_____ _____

[name printed] [street address]

_____

[city, state, zip]

WITNESS 2: _____ Dated: _____

[signature]

_____ _____

[name printed] [street address]

_____

[city, state, zip]