NEW MEXICO

ADVANCE HEALTH CARE D IRECTIVE

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.

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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:

(a) Request, review, and receive, to the extent I could do so individually, any information, verbal or written, regarding my physical or mental health, including, but not limited to, my individually identifiable health information or 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. 1320d and 45 CFR 160-164. I hereby authorize any physician, health care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy, or other covered health care provider, any insurance company, and the Medical Information Bureau, Inc. or other health care clearinghouse that has provided treatment or services to me, or that has paid for or is seeking payment from me for such services, to give, disclose, and release to my agent, without restriction, all of my individually identifiable health information and medical records regarding any past, present, or future medical or mental health condition. This authority given my agent shall supersede any other agreement which I may have made with my health care providers to restrict access to or disclosure of

(b) Execute on my behalf any releases or other documents that may be required in order to obtain this information; and

(c) Consent to the disclosure of this information.

3. **WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE:** My agent's authority becomes effective when my primary physician and one other qualified health care professional determine that I am unable to make my own health care decisions.

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If I initial this box **[_____]**, my agent's authority to make health care decisions for me takes place immediately and shall remain in effect despite my later incapacity.

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.

5. **NOMINATION OF GUARDIAN:** If a guardian 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 guardian, I nominate the alternate agent whom I have named.

PART 2

INSTRUCTIONS FOR HEALTH CARE

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 this part of the form. If you do fill out this part of the form, you may cross out any wording you do not want.

6. **END-OF-LIFE DECISIONS:** If I am unable to make or communicate decisions regarding my health care, and IF (i) I have an incurable or irreversible condition that will result in my death within a relatively short time, OR (ii) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, OR (iii) the likely risks and burdens of treatment would outweigh the expected benefits, THEN 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 initialed below in one of the following three boxes:

(INITIAL ONE)

_____ **I Choose NOT To Prolong Life**: I do not want my life to be prolonged.

_____ **I Choose To Prolong Life:** I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

_____ **I Choose To Let My Agent Decide**: My agent under my power of attorney for health care may make life-sustaining treatment decisions for me.

7. **ARTIFICIAL NUTRITION AND HYDRATION:** If I have chosen above NOT to prolong life, I also specify by marking my initials below:

(INITIAL ONE)

_____ **I DO NOT** want artificial nutrition OR

_____ **I DO** want artificial nutrition.

_____ **I DO NOT** want artificial hydration unless required for my comfort OR

_____ **I DO** want artificial hydration.

8. **RELIEF FROM PAIN:** Regardless of the choices I have made in this form and except as I state in the following space, I direct that the best medical care possible to keep me clean, comfortable and free of pain or discomfort be provided at all times so that my dignity is maintained, even if this care hastens my death:

(Add additional pages if needed)