DIRECTIVE TO PHYSICIANS AND FAMILY OR SURROGATES

Advance Directives Act (see §166.033, Health and Safety Code)

Instructions for completing this document:

This is an important legal document known as an Advance Directive. It is designed to help you communicate your wishes about medical treatment at some time in the future when you are unable to make your wishes known because of illness or injury. These wishes are usually based on personal values. In particular, you may want to consider what burdens or hardships of treatment you would be willing to accept for a particular amount of benefit obtained if you were seriously ill.

You are encouraged to discuss your values and wishes with your family or chosen spokesperson, as well as your physician. Your physician, other health care provider, or medical institution may provide you with various resources to assist you in completing your advance directive. Brief definitions are listed below and may aid you in your discussions and advance planning. Initial the treatment choices that best reflect your personal preferences. Provide a copy of your directive to your physician, usual hospital, and family or spokesperson. Consider a periodic review of this document. By periodic review, you can best assure that the directive reflects your preferences.

In addition to this advance directive, Texas law provides for two other types of directives that can be important during a serious illness. These are the Medical Power of Attorney and the Out-of-Hospital Do-Not-Resuscitate Order. You may wish to discuss these with your physician, family, hospital representative, or other advisers. You may also wish to complete a directive related to the donation of organs and tissues.

DIRECTIVE

I, Betsy Smith-Johnson, recognize that the best health care is based upon a partnership of trust and communication with my physician. My physician and I will make health care or treatment decisions together as long as I am of sound mind and able to make my wishes known. If there comes a time that I am unable to make medical decisions about myself because of illness or injury, I direct that the following treatment preferences be honored:

If, in the judgment of my physician, I am suffering with a terminal condition from which I am expected to die within six months, even with available life-sustaining treatment provided in accordance with prevailing standards of medical care:

✓ I request that all treatments other than those needed to keep me comfortable be discontinued or withheld and my physician allow me to die as gently as possible; OR

____ I request that I be kept alive in this terminal condition using available life-sustaining treatment. (THIS SELECTION DOES NOT APPLY TO HOSPICE CARE.)

If, in the judgment of my physician, I am suffering with an irreversible condition so that I cannot care for myself or make decisions for myself and am expected to die without life-sustaining treatment provided in accordance with prevailing standards of medical care:

✓ I request that all treatments other than those needed to keep me comfortable be discontinued or withheld and my physician allow me to die as gently as possible; OR

____ I request that I be kept alive in this irreversible condition using available life-sustaining treatment. (THIS SELECTION DOES NOT APPLY TO HOSPICE CARE.)

Additional requests: (After discussion with your physician, you may wish to consider listing particular treatments in this space that you do or do not want in specific circumstances, such as artificially administered nutrition and hydration, intravenous antibiotics, etc. Be sure to state whether you do or do not want the particular treatment.)

I don't want to be kept alive on machines if there is no chance I will ever get better

After signing this directive, if my representative or I elect hospice care, I understand and agree that only those treatments needed to keep me comfortable would be provided and I would not be given available life-sustaining treatments.

If I do **not** have a Medical Power of Attorney, and I am unable to make my wishes known, I designate the following person(s) to make health care or treatment decisions with my physician compatible with my personal values:

1. Charles Johnson (son)
2. Debra Johnson (daughter)

(If a Medical Power of Attorney has been executed, then an agent already has been named and you should not list additional names in this document.)

If the above persons are not available, or if I have not designated a spokesperson, I understand that a spokesperson will be chosen for me following standards specified in the laws of Texas.

If, in the judgment of my physician, my death is imminent within minutes to hours, even with the use of all available medical treatment provided within the prevailing standard of care, I acknowledge that all treatments may be withheld or removed except those needed to maintain my comfort. I understand that under Texas law this directive has no effect if I have been diagnosed as pregnant. This directive will remain in effect until I revoke it. No other person may do so.

Signed Betsy Smith-Johnson Date 11-5-2015

City, County, State of Residence San Antonio, Bexar County, Texas

Two competent adult witnesses must sign below, acknowledging the signature of the declarant. The witness designated as **Witness 1** may not be a person designated to make a health care or treatment decision for the patient and may not be related to the patient by blood or marriage. This witness may not be entitled to any part of the estate and may not have a claim against the estate of the patient. This witness may not be the attending physician or an employee of the attending physician. If this witness is an employee of a health care facility in which the patient is being cared for, this witness may not be involved in providing direct patient care to the patient. This witness may not be an officer, director, partner, or business office employee of a health care facility in which the patient is being cared for or of any parent organization of the health care facility.

Witness 1 [illegible] 11/5/15 Witness 2 Tanya Williams Nov 15, 2015

MyDirectives®

HIPAA Authorization Form

Betsy Smith-Johnson

Important note to readers of this document:

To verify that this document is the most current version available for Betsy Smith-Johnson, please click here, or go to https://staging2.mydirectives.com/verify and enter this ID: **3171c44** and this check sum: **0Vv9kA87wu**, or scan the QR code on the left.

ADVault, Inc., a Texas corporation ("ADVault"), is requesting *Betsy Smith-Johnson*, or his or her representative ("Patient"), to authorize the use and/or disclosure of certain Protected Health Information (as defined in U.S. Federal Regulations 45 CFR 164.501) between ADVault and hospitals and other medical treatment centers, as well as other third parties designated by Patient, subject to the requirements of the United States Federal Health Insurance Portability and Accountability Act of 1996 (each, a "Covered Entity"). The Protected Health Information for which authorization is requested can be specifically described as advanced medical directives and other indicators of patient treatment preference, including without limitation medical proxies, living wills, Do-Not-Resuscitate orders and organ donation forms, as well as the Patient's identifying information linking the Patient to the Protected Health Information and/or information related to Patient's current and future health care, medical history, treatment, or any other related information. Authorization for the use and/or disclosure of such Protected Health Information is requested for purposes of permitting ADVault to store and send to the Covered Entities, and the Covered Entities to provide ADVault, as well as to locate, retrieve, view and print, such advanced medical directives and Protected Health Information to determine the Patient's treatment preferences in a time of need. ADVault may disclose such Protected Health Information either directly to a Covered Entity or indirectly across an electronic health record, benefits verification or health information exchange platform in which ADVault participates.

Conditions

- The Patient agrees that ADVault and the Covered Entities may disclose the Patient's Protected Health Information to each other only for purposes listed above.
- Once the information above is released, the information may be subject to re-disclosure by ADVault or a Covered Entity and may not be protected under the privacy rules promulgated under the United States Federal Health Insurance Portability and Accountability Act of 1996.
- The Covered Entity will provide the Patient with a copy of the Protected Health Information for which this authorization is being sought upon the written request of the Patient.
- The Covered Entity may not condition treatment, payment, enrollment, or eligibility for benefits (as applicable) on whether the Patient signs this authorization.
- The Patient is voluntarily signing this authorization.
- The Patient will receive a copy of the signed authorization.
- This authorization will remain in effect until it is revoked by the Patient, and no further use or disclosure of the Patient's Protected Health Information is permitted to the above-stated person or entity beyond that date.
- The Patient has the right to revoke this authorization at any time. This revocation must be in writing, and submitted to the following address: ADVault, Inc., 740 E. Campbell Rd. Suite 825, Richardson, Texas 75081, United States of America.
- Once this authorization is revoked, ADVault and the Covered Entities will not use or disclose the Protected Health Information for the above-stated purpose except to the extent that ADVault or a Covered Entity has already relied on the authorization.

Signatures

Patient/Legal Representative: *Betsy Smith-Johnson* Date: *12/4/2020*

If Legal Representative, relationship to Patient: _____

Witness: _____ Date: _____

To provide your hospital/healthcare provider with a link to an Official Copy of this document,
click "Send my advance care planning documents..." from your My Dashboard page at www.mydirectives.com.

A|D Vault™

To verify that this document is the most current version available for Betsy Smith-Johnson, please click here, or go to https://staging2.mydirectives.com/verify and enter this ID: **3171c44** and this check sum: **0Vv9kA87wu**, or scan the QR code on the left.