1. Advance Health Care Directive   
   of   
   {{ client.name }}

I, {{ client.name }}, the principal, an adult of sound mind, execute this Health Care Power of Attorney under Utah Code Sections 75-2a-107, freely and voluntarily, with an understanding of its purposes and consequences. I intend my statements to constitute clear and convincing evidence of my wishes concerning medical and mental health treatment.

# Health Care Agent

## Designation of Healthcare Agent

{%p if hc\_number\_c == 1 %}

I designate {{ hcpoagentsclient[0].name }} to serve as my Healthcare Agent. I give my Healthcare Agent the power to make decisions with regard to my health care if I am unable to make my own health care decisions.

{%p elif hc\_number\_c == 2 %}

I designate {{ hcpoagentsclient[0].name }} to serve as my Healthcare Agent. I give my Healthcare Agent the power to make decisions with regard to my health care if I am unable to make my own health care decisions.

If {{ hcpoagentsclient[0].name }} is unwilling or unable to serve, I designate {{ hcpoagentsclient[1].name }} as alternate Healthcare Agents to exercise the powers and discretions set forth in this instrument.

{%p else %}

I designate {{ hcpoagentsclient[0].name }} to serve as my Healthcare Agent. I give my Healthcare Agent the power to make decisions with regard to my health care if I am unable to make my own health care decisions.

If {{ hcpoagentsclient[0].name }} is unwilling or unable to serve, I designate the individuals in the order listed below as alternate Healthcare Agents to exercise the powers and discretions set forth in this instrument.

{%p for agent in add\_separators(hcpoagentsclient[1:], separator=‘, Alternate’, last\_separator=‘, Alternate’, end\_mark=‘, Alternate’) %}

{{ agent }}

{%p endfor %}

{%p endif %}

## Duration

This power of attorney terminates, upon the earlier of my death or its revocation as provided in this instrument, except the HIPAA provisions described in Section 2.04 which continue to be in effect until two years after my death.

## General Grant

My Healthcare Agent has authority to do all acts related to my personal care, residential placement, and medical treatment that my Healthcare Agent determines to be appropriate, including but not limited to the items specifically mentioned in this instrument. If my Healthcare Agent is not available, I intend the following statements to guide decisions about my care and treatment.

## Effect on Legal Capacity

A formal adjudication of my incapacity is not required for my Healthcare Agent to exercise the authority granted by me under this instrument.

# Health and Personal Powers

## Instructions Concerning Medical Evaluations and Treatment

In exercising the authority granted to my Healthcare Agent, my Healthcare Agent is instructed to discuss with me the specifics of any proposed decision regarding my medical care and treatment if I am able to communicate in any manner however rudimentary, even by blinking my eyes. My Healthcare Agent is further instructed that if I am unable to give an informed consent to medical treatment, my Healthcare Agent shall give or withhold consent based upon any treatment choices I have expressed while competent, whether under this instrument or otherwise. If my Healthcare Agent cannot determine the treatment choice I would want made under the circumstances, then I request that my Healthcare Agent make the choice for me based upon what my Healthcare Agent believes to be in my best interests. I request that my Healthcare Agent’s decision be guided by taking into account:

The provisions of this instrument;

Any preferences that I may previously have expressed on the subject;

What my Healthcare Agent believes I would want done in the circumstances if I were able to express myself; and

Any information given to my Healthcare Agent by the physicians treating me as to my medical diagnosis and prognosis and the intrusiveness, pain, risks, and side effects of the treatment.

I want to leave my family, friends and persons who care about me with assurances of my love, and without the burdens of guilt or conflict. My purposes in leaving these instructions are to alleviate uncertainty that otherwise may arise in connection with decisions about my medical care, to promote family harmony and to clarify instructions to my health care providers. My Healthcare Agent’s authority to act on my behalf concerning my medical care includes, but is not limited to, decisions concerning artificial life support, medical treatment, surgery and other medical procedures; artificial nourishment and hydration; resuscitation decisions (including Do Not Resuscitate [DNR] orders and CPR directives); amputation of my limbs; blood transfusions; experimental drugs and medical procedures; the administration of pharmaceutical agents; and arrangements for my long-term care.

I affirm my belief in the importance and value of my personal dignity, both in living and in dying.

## Long-Term or Hospice Care

My Healthcare Agent is authorized to select a facility for my nursing, convalescent or hospice care and to establish my residence and placement in a secure unit therein if, in my Healthcare Agent’s sole and exclusive discretion, the facility provides the quality of care appropriate for my medical needs and mental condition. For the purposes of arranging or providing long-term care, my Healthcare Agent has authority to facilitate my transportation and establish my legal residence within or beyond the state of Utah.

## Maintain Me in my Residence

My Healthcare Agent is authorized to take whatever steps are necessary or advisable to enable me to remain in my personal residence as long as it is reasonable under the circumstances. I realize that my health may deteriorate so that it becomes necessary to have round-the-clock nursing care if I am to remain in my personal residence, and I direct my Healthcare Agent to obtain that care, including any equipment that might assist in my care, as is reasonable under the circumstances. Specifically, I do not want to be hospitalized or put in a convalescent or similar home as long as it is reasonable to maintain me in my personal residence.

## HIPAA Release Authorization

I intend for my Healthcare Agent to be treated as I would be with respect to my rights regarding the use and disclosure of 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 (aka HIPAA), 42 U.S.C. § 1320d and 45 C.F.R. §§ 160-164 and applies even if that person has not yet been appointed as Healthcare Agent but is next in line to become Healthcare Agent.

I 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 Healthcare Agent, without restriction all of my individually identifiable health information and medical records regarding any past, present or future medical or mental health condition, to include all information relating to the diagnosis and treatment of mental illness, drug or alcohol abuse, sexually transmitted diseases and HIV/AIDS.

The authority given my Healthcare Agent supersedes 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 authority given my Healthcare Agent expires two years after my death or if I revoke the authority in writing and deliver it to my health care provider.

## Medical Information and Medical Records

Acting on my behalf, my Healthcare Agent may have access to all of my medical information and photocopies of my medical records from my health care providers including, but not limited to, physicians, dentists, podiatrists, physical therapists, chiropractic physicians and chiropractors, pharmacists, optometrists, psychologists, social workers, hospitals, hospices and other treatment facilities; may disclose medical and related information concerning my treatment to appropriate health care providers; may admit or transfer me to such hospitals, hospices, or treatment facilities as my Healthcare Agent determines to be in my best interests.

In order for my Healthcare Agent to fulfill his or her duties, my treating physician or hospital is to discuss with my Healthcare Agent my medical condition and to disclose all medical records.

## Employ and Discharge Health Care Personnel

My Healthcare Agent may employ and discharge medical personnel including physicians, psychiatrists, dentists, nurses, and therapists as my Healthcare Agent determines necessary for my physical, mental and emotional well-being, and to direct my Trustee or my Agent under a financial power of attorney to pay them or any of them, reasonable compensation.

## Pain Relief

I want to ensure that my Healthcare Agent and physician protect my comfort and freedom from pain insofar as possible. I authorize my Healthcare Agent to consent on my behalf to the administration of whatever pain-relieving drugs and surgical pain relieving procedures my Healthcare Agent, upon medical advice, believes may provide comfort to me, even though such drugs or procedures may lead to pharmaceutical addictions, lower blood pressure, lower levels of breathing, or may hasten my death. Even if artificial life support or aggressive medical treatment has been withdrawn or refused, I want to be kept as comfortable as possible, and I do not want to be neglected by medical or nursing staff.

## Grant Releases

My Healthcare Agent may grant, in conjunction with any instructions given under this instrument, releases to hospital staff, physicians, nurses and other medical and hospital administrative personnel who act in reliance on instructions given by my Healthcare Agent or who render written opinions to my Healthcare Agent in connection with any matter described in this instrument from all liability for damages suffered or to be suffered by me; and to sign documents titled or purporting to be a “Refusal to Permit Treatment” and “Leaving Hospital Against Medical Advice” as well as any necessary waivers of or releases from liability required by any hospital or physician to implement my wishes regarding medical treatment or non-treatment.

## Advance Directives

Article 4 contains my Advance Directives under the laws of the state of Utah. The decision of my Healthcare Agent prevails over any contrary provision in my Advance Directives.

If I become unconscious or incompetent in a state where my Advance Directives or Agent Designation is not honored, I authorize my Healthcare Agent to transport me or arrange for my transportation to a jurisdiction where my medical directives will be enforceable.

# Legal and Administrative Powers and Provisions

## Guardian

The authority conferred upon my Healthcare Agent obviates the need for appointment of a guardian. But if any proceeding is commenced for the appointment of a guardian, I nominate my Healthcare Agent to serve as my guardian, without bond.

## Conflict or Ambiguity

Notwithstanding any other provisions herein, if my health care directives do not make clear what my desires would be in a given situation or if the directions and decisions of my Healthcare Agent appear to be in conflict with my health care directives, then the directions and decisions of my Healthcare Agent shall prevail, and I hereby further direct that my health care providers follow the directions and decisions of my Healthcare Agent. I have full confidence in my Healthcare Agent and I also know that even where I have set forth my wishes, circumstances may indicate that other decisions should be made. The provisions contained in this instrument are paramount if and when they are inconsistent with any provision contained in any other instrument.

## Third-Party Reliance

Third parties may accept as binding the instructions and decisions of my Healthcare Agent regarding my medical treatment. No person or medical facility or institution may incur any liability to me or to my estate by complying with my Healthcare Agent’s instructions. My Healthcare Agent is authorized to execute consents, waivers, and releases of liability on my behalf and on behalf of my estate to all medical personnel who comply with my Healthcare Agent’s instructions. Furthermore, I authorize my Healthcare Agent to indemnify and hold harmless, at my expense, any third party who accepts and acts under this power of attorney, and I agree to be bound by any indemnity entered into by my Healthcare Agent.

## Enforcement by Healthcare Agent

I authorize my Healthcare Agent to seek on my behalf and at my expense:

A declaratory judgment from any court of competent jurisdiction interpreting the validity of this instrument or any of the acts authorized by this instrument, but a declaratory judgment is not necessary in order for my Healthcare Agent to perform any act authorized by this instrument; or

An injunction requiring compliance with my Healthcare Agent’s instructions by any person providing medical or personal care to me; or

Actual and punitive damages against any person responsible for providing medical or personal care to me who willfully fails or refuses to follow my Healthcare Agent’s instructions.

## Release of Healthcare Agent’s Personal Liability

My Healthcare Agent shall not incur any personal liability to me or my estate arising from the good faith exercise of discretion or performance of acts and duties relating to my medical treatment and personal care.

## Reimbursement of Healthcare Agent

My Healthcare Agent is entitled to reimbursement for all reasonable expenses arising from the performance of acts and duties relating to my medical treatment and personal care under this instrument.

## Validity of Copies

Photocopies (photocopies include: facsimiles and digital or other reproductions, hereafter referred to collectively as “photocopy”) of this instrument may be effective and enforceable as originals, and third parties are entitled to rely on photocopies of this instrument for the full force and effect of all stated terms.

## Interstate Enforceability

It is my intention that the terms of this instrument be honored in any jurisdiction, regardless of its conformity to that jurisdiction’s technical requirements and legal formalities.

## Amendment and Revocation

I reserve the right to revoke my Healthcare Agent’s authority orally or in writing; provided, however, I am able to give informed consent.

## Revocation of Prior Powers

Unless otherwise expressly provided herein, this Health Care Power of Attorney expressly supersedes all powers of attorney regarding my health care that I previously may have executed. Execution of this instrument does not, however, affect any other unrelated powers previously conveyed by me through general or limited powers of attorney, or my living will, which powers and living will are to continue in full force and effect until revoked by me or otherwise terminated.

# Advance Directives

## Guidelines for the Cessation of Life-Sustaining Treatment

If my death becomes imminent, I am in a persistent vegetative state, or I have a terminal illness or incurable condition, then I do not want my life to be prolonged and I do not want life-sustaining treatment, beyond comfort care, that would serve only to artificially delay the moment of my death. I want to die naturally, with only the administration of medication or the performance of any medical procedures deemed necessary to provide me with comfort and care or to alleviate pain, even though they may shorten my remaining life.

Notwithstanding my other directions I do want the use of all medical care necessary to treat my condition until my physicians reasonably conclude that my condition is terminal or is irreversible and incurable or I am in a persistent vegetative state.

Except as modified by any guidelines stated above, the term “life-sustaining treatment” shall include, without being limited to, nutrition and hydration administered by invasive procedures, antibiotics, respirators, pacemakers, renal dialysis, or any other mechanical devices designed to assist the functioning of organs; transfusion of blood and blood products; and in the event of cardiac or cardiopulmonary arrest, resuscitative procedures.

## Pain Relief

I consent to the administration of whatever pain-relieving drugs and surgical pain relieving procedures my Health Care Agent or surrogate, upon medical advice, believes may provide comfort to me, even though such drugs or procedures may lead to pharmaceutical addictions, lower blood pressure, lower levels of breathing, or may hasten my death. Even if artificial life support or aggressive medical treatment has been withdrawn or refused, I want to be kept as comfortable as possible, and I do not want to be neglected by medical or nursing staff.

## Statement of My Intent

In the absence of my ability to give directions regarding the use of such life-sustaining treatment, it is my intent that this declaration be honored by my family and physicians as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences of such refusal.

## Release of Liability

I hereby release and hold harmless any person who, in good faith, terminates life-sustaining procedures in accordance with the guidelines in this declaration.

Execution of this Advance Health Care Directive

I, {{ client.name }}, sign my name to this Advance Health Care Directive on the date indicated below and being first duly sworn, do declare to the undersigned authority that I sign and execute this instrument as my Advance Health Care Directive and that I sign it willingly or willingly direct another to sign for me, that I execute it as my free and voluntary act for the purposes expressed in this Advance Health Care Directive and that I am eighteen years of age or older, of sound mind and under no constraint or undue influence. 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 form naming a health care agent or expressing any advance directive that I have completed in the past.

Dated \_\_\_\_\_\_\_\_\_\_\_ \_\_\_, 20\_\_\_\_.

{{ client.name }}, Principal

**Witness Attestation**

I, the undersigned, declare that the principal signed or marked this Health Care Power of Attorney in my presence and appears to me to be of sound mind and free from duress. I am 18 years of age or older, and I am not:

1. Related to the declarant by blood or marriage;
2. 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, or the beneficiary of a life insurance policy, trust, qualified plan, pay on death account or transfer on death deed;
3. Directly financially responsible for the declarant’s medical care;
4. 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;
5. In any way going to benefit financially from the death of the declarant; or
6. The appointed agent or alternate agent.

In the event the principal acknowledging this Advance Health Care Directive is physically unable to sign or mark this document, I verify that the principal directly indicated to me that this Advance Health Care Directive expresses the principal’s wishes and that the principal intends to adopt the Advance Health Care Directive at this time.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, Witness