Health Care Directive

Pursuant to Minnesota Statute 145C

I, (the below-named PRINCIPAL) hereby appoint the below named HEALTH CARE AGENT to make all health care related decisions when I am unable to speak or decide for myself. My HEALTH CARE AGENT must follow instructions here, or wishes I have made known, or otherwise act in my best interest. I know I can terminate/change/override this Health Care Directive at any time, even by my verbal order.

Healthcare decisions delegated to the HEALTH CARE AGENT include:
(A) The power to give, refuse, or withdraw consent to any care, treatment, service, or procedures. This includes deciding whether to stop or not start health care that is keeping me or might keep me alive, and deciding about intrusive mental health treatment.
(B) Choose my health care providers.
(C) Choose where I live and receive care and support when those choices relate to my health.
(D) Review my medical records and have the same rights that I would have to give my medical records to other people.
(E) To decide whether to donate any parts of my body, including organs, tissues, and eyes, when I die.
(F) To decide what will happen with my body when I die (burial, cremation).

To withdraw any of the preceding powers, cross out the line and have initialed by the PRINCIPAL and/or use the following space to provide more specific instructions.

____

____

Please choose one of the two following general health care instructions in case of medical emergency and/or the HEALTH CARE AGENT is not immediately available

[ ] A. Provide reasonable medical intervention to extend life.

[ ] B. Provide comfort care rather than attempting life extending medical intervention.

Name of HEALTH CARE AGENT_________________________ Relation to PRINCIPAL_________________

Phone________________________ Alternate Phone____________________

Name of PRINCIPAL_______________________ Signature_________________________ Date__________

To be valid the PRINCIPAL'S signature must be notarized *OR* have two witnesses

Notary Name___________________________

Signature_______________________________

Date______________ County______________

Stamp

Witnesses must be 18+, not be the HEALTH CARE AGENT, and only one may be a health care provider

Witness 1 Name________________________

Signature___________________________ Date________

Witness 2 Name________________________

Signature___________________________ Date ________

This is an important document. Keep the original safe and accessible, and make copies to provide to people and providers with whom these powers are used.