GEORGIA ADVANCE DIRECTIVE FOR HEALTH CARE
by
JANE DOE
Date of Birth: _____

This advance directive for health care has four parts:

PART ONE: HEALTH CARE **AGENT**. *This part allows you to choose someone to make health care decisions for you when you cannot (or do not want to) make health care decisions for yourself. The person you choose is called a health care agent. You may also have your health care agent make decisions for you after your death with respect to an autopsy, organ donation, body donation, and disposition of your body. You should talk to your health care agent about this important role.*

PART TWO: HEALTH CARE **TREATMENT PREFERENCES**. *This part allows you to state your health care treatment preferences if you have a terminal condition or if you are in a state of permanent unconsciousness. PART TWO will become effective only if you are unable to communicate your health care treatment preferences. Reasonable and appropriate efforts will be made to communicate with you about your health care treatment preferences before PART TWO becomes effective. You should talk to your family and others close to you about your treatment preferences.*

PART THREE: **GUARDIANSHIP**. *This part allows you to nominate a person to be your guardian should one ever be needed.*

PART FOUR: **EFFECTIVENESS AND SIGNATURES**. *This part requires your signature and the signatures of two witnesses. You must complete PART FOUR if you have filled out any other part of this form.*

You may fill out any or all of the first three parts listed above. You must fill out PART FOUR of this form in order for this form to be effective.

You should give a copy of this completed form to people who might need it, such as your health care agent, your family, and your physician. Keep a copy of this completed form at home in a place where it can easily be found if it is needed. Review this completed form periodically to make sure it still reflects your preferences. If your preferences change, complete a new advance directive for health care.

You may revoke this completed form at any time. This completed form will replace any advance directive for health care, durable power of attorney for health care, health care proxy, or living will that you have completed before completing this form.

PART ONE

(1) HEALTH CARE AGENT

I select the following person as my health care agent to make health care decisions for me (all contact information is attached to this power):

_____

(2) BACK-UP HEALTH CARE AGENT

If my health care agent cannot be contacted in a reasonable time period and cannot be located with reasonable efforts for any reason my health care agent is unavailable or unable or unwilling to act as my health care agent, then I select the following, each to act successively in the order named, as my back-up health care agent(s):

First Successor:

(3) GENERAL POWERS OF HEALTH CARE AGENT

My health care agent will make health care decisions for me when I am unable to communicate my health care decisions or I choose to have my health care agent communicate my health care decisions.

My health care agent will have the same authority to make any health care decision that I could make. My health care agent's authority includes, for example, the power to:

1. Admit me to or discharge me from any hospital, skilled nursing facility, hospice, or other health care facility or service;

2. Request, consent to, withhold, or withdraw any type of health care; and

3. Contract for any health care facility or service for me, and to obligate me to pay for these services (but my health care agent will not be financially liable for any services or care contracted for me or on my behalf).

   Regardless of my medical condition, my health care agent *and all my named successor agents* will be my personal representative for all purposes of federal or state law related to privacy of medical records and will have the same access to my medical records that I have and can disclose the contents of my medical records to others for my ongoing health care. This provision is effective immediately.

   This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (aka HIPAA), 42 USC 1320d and 45 CFR 160-164.

   My health care agent may accompany me in an ambulance or air ambulance if in the opinion of the ambulance personnel protocol permits a passenger and my health care agent may visit or

consult with me in person while I am in a hospital, skilled nursing facility, hospice or other health care facility or service if its protocol permits visitation.

My health care agent may present a copy of the original form in lieu of the original form and the copy will have the same meaning and effect as the original.

I understand that under Georgia law:

My health care agent may refuse to act as my health care agent;

A court can take away the powers of my health care agent if it finds that my health care agent is not acting properly; and

My health care agent **does not have** the power to make health care decisions for me regarding psychosurgery, sterilization, or treatment of involuntary hospitalization for mental or emotional illness, mental retardation, or addictive disease.

(4) GUIDANCE FOR HEALTH CARE AGENT

When making health care decisions for me, my health care agent should think about what action would be consistent with past conversations we have had, my treatment preferences as express in PART TWO, my religious and other beliefs and values, and how I have handled medical and other important issues in the past. If what I would decide is still unclear, then my health care agent should make decisions for me that my health care agent believes are in my best interest, considering the benefits, burdens, and risks of my current circumstance and treatment options.

(5) POWERS OF HEALTH CARE AGENT AFTER DEATH

(A) My health care agent will have the power to *authorize* an AUTOPSY of my body.

(B) ORGAN DONATION AND DONATION OF BODY:

My health care agent will have the power to make a disposition of any part or all of my body for medical purposes pursuant to the Georgia Anatomical Gift Act.

(C) FINAL DISPOSITION OF BODY

My health care agent will have the power to make decisions about the final disposition of my body pursuant to my selection below:

I wish for my body to be:

_____ (Initials) Buried OR _____(Initials) Cremated

PART TWO: TREATMENT PREFERENCES

(6) CONDITIONS

PART TWO will be effective only if I am not able to understand the general nature of the health care procedure being consented to or refused, or I am not able to communicate my desires thereto; _____(Initials)

My condition will be determined in writing after personal examination by my attending physician and a second physician in accordance with currently accepted medical standards.

(7) TREATMENT PREFERENCES

If I am in any condition initialed above in Section (6) and I can no longer communicate my treatment preferences after reasonable and appropriate efforts have been made to communicate with me about my treatment preferences, then:

(A) _____ (Initials) Try to extend my life for as long as possible, using all medications, machines, or other medical procedures that in reasonable medical judgment could keep me alive. If I am unable to take nutrition or fluids by mouth, then I want to receive nutrition or fluids by tube or other medical means.

OR

(B) _____ (Initials) Allow my natural death to occur. I do not want any medications, machines, or other medical procedures that in reasonable medical judgment could keep me alive but cannot cure me. I do not want to receive nutrition or fluids by tube or other medical means except as needed to provide pain medication.

(8) PREGNANCY

I understand that under Georgia law, PART TWO generally will have no force and effect if I am pregnant unless the fetus is not viable and I indicate by initialing below that I want PART TWO to be carried out.

_____ (Initials) I want PART TWO to be carried out if my fetus is not viable.

PART THREE: NAMING A GUARDIAN

_____ (Initials) I nominate the person serving as my health care agent under PART ONE to serve as my guardian.

PART FOUR: EFFECTIVENESS AND SIGNATURES

This advance directive for health care will become effective only if I am unable or choose not to make or communicate my own health care decisions; HOWEVER, even if I am able to make decisions, the permission to access my medical records for my agent and my successor agents is effective immediately upon the signature on this document.

This form revokes any advance directive for health care, durable power of attorney for health care, health care proxy, or living will that I have completed before this date.

_____ (Initials) This advance directive for health care is effective on today's date and will remain effective until my death (and after my death for all purposes as set forth in this document.)

By signing below, I state that I am emotionally and mentally capable of making this advance directive for health care and that I understand its purpose and effect.

_____ _____
(Signature of Declarant) (Date)

The declarant signed this form in my presence or acknowledged signing this form to me. Based upon my personal observation, the declarant appeared to be emotionally and mentally capable of making this advance directive for health care and signed this form willingly and voluntarily.

_____ _____
(Signature of First Witness) (Date)

Print Name: _____
Address:

_____ _____
(Signature of Second Witness) (Date)
Print Name: _____
Address: