EMERGENCY MEDICAL INFORMATION
OF JOHN DOE

Emergency medical contacts:

1) Jane Doe: (888) 888-8888
2) Henry Smith: (999) 999-9999

I am on the following medications:

1) Blood-thinner (Daily, 25mg)
2) Allergy antihistamine (Daily)
3) Atorvastatin (Daily, to lower cholesterol, 25mg)

I have the following allergies:

1) Penicillin
2) Peanuts

My Living Will begins on the following page.

ADVANCE HEALTH CARE DIRECTIVE
OF JOHN DOE

ARTICLE I. CREATION OF POWER OF ATTORNEY FOR HEALTH CARE

a. **Designation of Agent.** I designate Jane Doe as my agent to make health care decisions on my behalf. She as of the execution of this Advance Health Care Directive resides at 123 Example Drive in Anytown, California. She can be reached by phone at (123) 456-7890.

b. **Alternate Agent.** If I revoke the above-named agent's authority or if the above-named agent is not willing, able, or reasonably available to make a health care decision for me, I designate Jacob Doe as my alternate agent. He as of the execution of this Advance Health Care Directive resides at 456 Example Drive in Anytown, California. He can be reached by phone at (123) 456-0987.

c. **Agent's Authority.** My agent is authorized to make all health care decisions on my behalf, to the same extent that I could make health care decisions for myself if I had the capacity to do so, including decisions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care to keep me alive, except as I state here or elsewhere in this document. Except as I have otherwise described in this document, my agent also has the authority to talk with health care personnel, receive information, and sign forms necessary to carry out such decisions.

d. **Effectiveness of Agent's Authority.** My agent's authority becomes effective when my primary physician, or alternatively, two qualified physicians, determine(s) that I am unable, for whatever reason, to make my own informed health care decisions, either temporarily or for the remainder of my life. If I regain my ability to make my own health care decisions, my agent's authority shall cease.

e. **Agent's Obligation.** My agent shall make health care decisions for me in accordance with these Power of Attorney provisions, any instructions I give elsewhere in this Advance Health Care Directive, any instructions I provide in a duly-executed and witnessed Last Will and Testament, 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 by my agent.

f. **Agent's Post-Death Authority.** My agent is authorized to make anatomical gifts, authorize an autopsy, and direct disposition of my remains, except as I state below, elsewhere in this Advance Health Care Directive, or in a duly-executed and witnessed Last Will and Testament.

g. **Nomination of Conservator.** If a conservator of my person needs to be appointed for me by a court, I nominate the agent designated in this Advance Health Care Directive. If that agent is not willing, able, or reasonably available to act as conservator, I nominate the individual identified as my alternate agent. I request that my conservator serve in such capacity without bond, or if a bond is otherwise required, I request that a minimum bond be set. I revoke all prior conservatorship nominations.

ARTICLE II. HEALTH CARE INSTRUCTIONS

a. **End-of-Life Decisions.** I direct that my health care providers and others involved in my health care provide, withhold, or withdraw treatment in accordance with the following preference of mine:
    i. I do not want my life to be prolonged if (1) I have an incurable or irreversible condition that will result in my death, (2) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (3) the likely risks and burdens of treatment would outweigh the expected benefits.
b. **Relief from Pain.** I direct that treatment for the alleviation of pain or discomfort be provided at all times, even if it hastens my death.

ARTICLE III. DONATION OF ORGANS UPON DEATH

a. **Donation.** Upon my death, I donate any needed organs, tissues, or parts.
b. **Purpose.** My donation is for the purpose(s) of transplantation.

ARTICLE IV. GENERAL PROVISIONS

a. **Definition of "Health Care Decision."** A "health care decision" means a decision regarding my health care, including, but not limited to, selecting and discharging health care providers and institutions; approving or disapproving diagnostic tests, surgical procedures, and medication programs; and directing the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care, including cardiopulmonary resuscitation. "Health care" means any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect my physical or mental condition.
b. **HIPAA and Similar Laws.** Pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and any similar state laws, and exclusively for the purpose of making a determination of my incapacity or inability to direct my own health care decisions and obtaining a physician's affidavit of such, I authorize any health care provider to disclose to my health care agent named herein, as applicable, any pertinent individually identifiable health information sufficient to determine whether I am by reason of illness or mental or physical disability incapacitated or incapable of making my own health care decisions. In exercising such authority, my health care agent shall constitute my "personal representative" as defined by HIPAA and any similar state laws. Further, upon the determination of my incapacitation or incapability to make my own health care decisions, I direct that my health care agent named herein to be treated as my "personal representative" under HIPAA and any similar state laws, and as such 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.
c. **Effect of Copy.** A copy of this Advance Health Care Directive has the same force and effect as the original.
d. **Severability.** If a court invalidates any provision of this Advance Health Care Directive, such invalidation shall not affect the rest of this Advance Health Care Directive. Any remaining provisions that can be given effect without the invalidated provision shall remain in full force and effect.
e. **Revocation.** I revoke any and all Advance Health Care Directives, also known as Living Wills, I have previously made and duly executed.

f. Indemnification. All persons or entities that in good faith endeavor to carry out the provisions of this document shall not be liable to me, my estate, or my heirs for any damages or claims arising out of their actions or inactions based on this document. My estate shall hold such persons or entities harmless.

[*Remainder of page intentionally left blank. Signature page follows*]

Signed by John Doe at Anytown, California.

_____
Signature

_____
Date

STATEMENT OF WITNESSES. I declare under penalty of perjury under the laws of California (1) that the individual who signed or acknowledged this Advance Health Care Directive is personally known to me, or that the individual's identity was proven to me by convincing evidence, (2) that the individual signed or acknowledged this Advance Health Care Directive in my presence, (3) that the individual appears to be of sound mind and under no duress, fraud, or undue influence, (4) that I am not a person appointed as an agent by this Advance Health Care Directive, and (5) that I am not the individual's health care provider, an employee of the individual's health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility for the elderly, nor an employee of an operator of a residential care facility for the elderly. I further declare under penalty of perjury under the laws of California that I am not related to the individual executing this Advance Health Care Directive, or the individual's spouse, by blood, marriage, or adoption, and to the best of my knowledge, I am not entitled to any part of the individual's estate upon his or her death under a will now existing or by operation of law.

_____	_____
Signature of Witness #1	*Signature of Witness #2*
_____	_____
Name of Witness #1	*Name of Witness #2*
_____	_____
Address of Witness #1	*Address of Witness #2*
_____	_____
Date	*Date*