1. **Purpose of the Form.** I wish and expect, to the extent that I am able, to be fully informed about and to participate in any and all decision making regarding my health care, including any procedures that may be used to prolong or sustain my life. This form is intended to authorize the agent(s) named below to act on my behalf. I currently reside at:

_____

I was born on _____.

2. **Appointment of Health Care Agent.** I appoint _____

who is my _____, as my primary health care agent.
(spouse, brother, sister, son, daughter, friend, etc.)

They can be contacted by mail at:

_____

and by telephone at _____. If for any reason my primary health care

agent is not reasonably available to serve, I appoint _____

who is my _____, as my alternative health care agent until such time as my primary health care agent is available. My alternative agent can be contacted by mail at:

_____

and by telephone at _____

When I refer to Agent, I mean either my primary health care agent or my alternative health care agent.

3. **Disclosure of Health Records and Health Information.** I waive all medical privilege in favor of any Agent I appoint under this Health Care Directive. My Agent may assert on my behalf the right to receive, review and obtain copies of my medical records and to consent to disclosure of those records. My health care agent has the same right as I would have to receive, review, and obtain copies of my medical records and to consent to disclosure of those records.

Whenever I lack capacity to make health care decisions for myself, my health care agent may act on my behalf to the maximum extent allowed by Minnesota and federal law, and may make any health care decision for me that I otherwise would be allowed or required to make for myself, as provided for in Minnesota Chapter 145C.

DISCLOSURE OF HEALTH INFORMATION GOVERNED BY HIPAA.

Notwithstanding any provision in this health care directive to the contrary, and whether or not I have or retain decision making capacity for any other purpose, I hereby grant my Agent the authority to:

1. receive, review, obtain copies, and otherwise have access to and obtain disclosure of my health records and any protected health information held in any form, including paper, electronic, written, or oral, regarding any past, present, or future medical or mental health condition, without limitation, by any of my health care providers as if my health care agent were me; and

2. to be recognized as my personal representative under the Health Insurance Portability and Accountability Act of 1996, 42 USC 1320d ("HIPAA"), by any health care provider, insurance company or 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, or is maintaining any protected information about me; and

3. to execute or otherwise provide specific authorizations or consents for the use and disclosure of my health records and my protected health information by my health care providers and to third parties for any purpose my health care agent deems advisable.

This authorization shall not expire and shall remain in effect as long as my health care directive remains in effect.

4. **Powers of Agent.**

4.1 My Agent must act consistently with my wishes as stated in this document or as I have otherwise made known to my Agent.

4.2 My Agent has the power to make any health care decision for me when, in the judgment of my attending physician, I lack decision-making capacity. This power includes the power to give consent, to refuse consent, or to withdraw consent to any care, treatment, service or procedure to maintain, diagnose or otherwise affect my physical or mental condition, including giving me food or water by artificial means. My Agent has the power, where consistent with the laws of this state, to make a health care decision to withhold or stop health care necessary to keep me alive.

4.3 My Agent may choose where I live when I need health care and what personal security measures are needed to keep me safe.

4.4 My Agent shall have all other powers and duties which are permitted or authorized by law to be exercised by an Agent on my behalf.

4.5 My Agent has no limitations on the right of the health care agent or any alternative health care agents to receive, review, obtain copies of, and consent to, the disclosure of my medical records.

5. **Nomination of Guardian.** If there is a petition for the appointment of a guardian to have authority with respect to decisions concerning life-sustaining procedures or other health care for me, I nominate, pursuant to Minnesota Statutes, the agent(s) designated in this Health Care Directive for appointment by the court as guardian. I ask that the guardian be given such authority to make health care decisions as may be permitted under Minnesota law.

6. **Organ Donation.**

☐ I wish to donate my organs, tissue and other body parts

☐ I do not wish to donate my organs, tissue and other body parts

7. **Disposition of my Remains.** My Agent shall carry out my wishes by making all decisions about what will happen to my body when I die. My Agent shall also have all powers available under Minnesota Statutes, Sec. 149A.80, to the exclusion of all others including my next of kin.

☐ I request cremation of my remains.

☐ I request burial of my remains.

☐ My Agent shall decide whether my remains are cremated or buried.

8. **Revocation.** I hereby revoke any and all prior durable Powers of Attorney for Health Care, Adult Health Care Declarations, or other forms of "Living Will" executed by me.

(NOTE: Your signature must be signed in the presence of a Notary Public, who is not the agent or alternate agent, OR in the presence of two adult witnesses, neither of whom is the agent or alternate agent and not more than one of whom is a health care provider or an employee of a health care provider giving you direct care at the time of signing.)

Dated:_____ 2014 _____

Signature of Principal

OPTION 1: NOTARY

STATE OF MINNESOTA)
) ss.
COUNTY OF _____)

In my presence on _____, 2014, _____ acknowledged their signature on this document. I am not named as a health care agent or alternate health care agent in this document.

_____

Signature of Notary Public

OPTION 2: WITNESSES

In our presence on _____, 2014, the above-named principal acknowledged their signature on this document.

I hereby certify and attest that I am at least 18 years old and I am not named in this document to serve as a health care agent. I am not a health care provider or an employee of a health care provider giving direct care to the principal on the date listed above.

_____ _____

Signature of Witness Contact Phone Number

_____

Print Name of Witness

Address of Witness: _____

I hereby certify and attest that I am at least 18 years old and I am not named in this document to serve as a health care agent.

_____ _____

Signature of Witness Contact Phone Number

_____

Print Name of Witness

Address of Witness: _____

Minnesota law provides that a copy of your Health Care Directive carries the same authority as the original. Keep the original with your personal papers in a safe but accessible place (not in a safe deposit box). Distribute copies to your health care providers, family, health care agent, and alternate health care agent. This document should be part of your medical record at your physician's office and at the hospital, home care agency, hospice, or nursing facility where you receive your care.

Consult your treating Physician if you wish to obtain Provider Orders for Life Sustaining Treatment, (POLST) sometimes referred to as Do Not Resuscitate (DNR) or Do Not Intubate (DNI). For more information, visit www.polstmn.org .