RIVERSIDE
Advance Care Planning

APPOINTMENT OF A HEALTHCARE AGENT

I, _____, appoint the person(s) below to be my Healthcare Agent.

While I am capable of making an informed decision, I will make my own decisions about my health care. If I ever become incapable of making an informed decision, I appoint the person(s) below to be my healthcare agent(s).

Primary Agent Name_____

Address _____

Telephone _____ Cell Phone _____

If my primary agent is not available or is unable or unwilling to act as my agent, then I appoint the person below to serve in that capacity:

Secondary Agent Name _____

Address _____

Telephone _____ Cell Phone _____

My agent shall follow my desires and preferences. My agent shall be guided by information provided by my physicians as to the intrusiveness, pain, risks and side effects associated with treatment or nontreatment. My agent shall make decisions that are consistent with my religious beliefs or basic values. If my agent cannot determine what health care choice I would have made, then my agent shall make a choice based upon what my agent believes to be in my best interests.

Powers of My Healthcare Agent

(Please read carefully, and cross through any language you do not want. Add any language that you do want.)

I want my agent to be able to do the following:

A. To consent to or refuse or withdraw consent to any type of health care including, but not limited to, artificial respiration, artificially administered nutrition and hydration, and cardiopulmonary resuscitation. This authorization specifically includes the power to consent to the administration of dosages of pain-relieving medication in excess of recommended dosages in an amount sufficient to relieve pain, even if such medication carries the risk of addiction or of inadvertently hastening my death
B. To request, receive, and review any information regarding my physical or mental health, and to consent to the disclosure of this information
C. To employ and discharge my health care providers
D. To authorize my admission to or discharge from any medical care facility

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E. To authorize my admission to a health care facility for the treatment of mental illness for no more than 10 days provided I do not protest the admission
F. To continue to serve as my agent even if I become incapable of making an informed decision and then protest their authority
G. To authorize my participation in health care research that might benefit me
H. To authorize my participation in health care research to promote human well-being, even if it would not benefit me
I. To restrict the following people from visiting me while I am in a health care facility: _____ *(If this section is left blank, I do not want restrictions on visitors.)*
J. To donate all or part of my body for transplantation, therapy, research or education

My agent shall not be liable for the costs of my health care, based solely on the fact that they have been named as my agent on this document.

Additional powers of my agent, if any: _____

OPTIONAL: MY AGENT'S AUTHORITY OVER MY PROTEST

If you do not wish to use this section, cross through it and sign the center of the "X."

My Healthcare Agent may authorize my admission to a health care facility for the treatment of mental illness for no more than 10 days, even over my protest.

A physician's signature is required below *ONLY* if this section is used:

Physician Attestation: I certify that _____ is capable of making an informed decision, and understanding the consequences of these provisions.

Physician Signature: _____Date:_____

Physician name (please print) _____ Office Phone: _____

My Signature: _____ Date: _____

Two adult witnesses are required. It is not necessary to notarize. The witnesses below certify that this document was signed in their presence.

Witness #1 _____ Date: _____

Name of Witness (please print) _____

Witness #2 _____ Date: _____

Name of Witness (please print) _____

Discuss your thoughts about health care decisions with your Healthcare Agents, and give them a copy of this document. If you make changes, or complete a full Advance Directive at a later date, destroy this original and any copies that you distributed and give the new document to your Healthcare Agents, doctors, and family members.