**Advance Directive and Durable Power of Attorney for Health**

By: [NAME]

Date of Birth: [DOB]

DESIGNATION OF AGENT: I, , designate the following individual as my agent to make health

care decisions for me:

[Name]

[Address]

[Phone Number]

If I revoke my agent’s authority or if my agent is not willing, able or reasonably available to make a healthcare decision

for me, I designate as my first alternate agent:

[Name]

[Address]

[Phone Number]

If I revoke my agent’s authority or if my agent is not willing, able or reasonably available to make a health-care decision

for me, I designate as my second alternate agents:

[Name]

[Address]

[Phone Number]

[Name]

[Address]

[Phone Number]

(2) AGENT’S AUTHORITY: My agent is authorized to make all health-care decisions for me, including decisions to

provide, withhold, or withdraw artificial nutrition and hydration, and all other forms of health care to keep me alive.

(3) WHEN AGENT’S AUTHORITY BECOMES EFFECTIVE: My agent’s authority to make health-care decisions for me

takes effect immediately.

(4) AGENT’S OBLIGATION: My agent shall make health-care decisions for me in accordance with this power of

attorney for health care, any instructions I give in this form, 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 to my agent.

(5) AGENT’S POSTDEATH AUTHORITY: My agent is authorized to make anatomical gifts, authorize an autopsy, and

direct disposition of my remains, except as I state here on this form:

I wish for my functioning and viable organs to be donated.

If there are questions regarding the cause of death, I authorize my agent to seek an autopsy.

(6) 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 form. If that agent is not willing, able, or reasonably available to act as

conservator, I nominate the alternate agents whom I have named, in the order designated.

(7) END-OF-LIFE DECISIONS: I direct that my health-care providers and others involved in my care provide, withhold,

or withdraw treatment in accordance with the choice I have marked below:

\_\_\_\_\_\_\_ (a) Choice NOT to Prolong Life

I do not want my life to be prolonged if (1) I become comatose, and to a reasonable degree of medical certainty, I will not regain consciousness, (2) the likely risks (brain-damage, unable to speak, blindness, dementia, etc.) and burdens of treatment would outweigh the expected benefits, or (3) reviving me would, with certainty, leave me paralyzed & wheelchair-bound for the remainder of my life, no matter how old I am at the time.

\_\_\_\_\_\_\_ (b) Choice to Prolong Life

I want my life to be prolonged as long as possible within the limits of generally accepted health-care standards.

(8) RELIEF FROM PAIN: I direct that treatment for alleviation of pain or discomfort should be provided, at all times,

even if it hastens my death.

(9) EFFECT OF COPY: A copy of this form has the same effect as the original.

(10) AUTHORIZATION FOR USE/RELEASE OF HEALTH INFORMATION: I authorize any person, doctor, or

organization to release or disclose protected health information to my health care agent.

(11) VALID IN ALL STATES: This document is intended to be valid in any jurisdiction in which it is presented. If any

provision is considered unenforceable, the other provisions shall remain valid and binding.

(12) SIGNATURE:

Your Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[Your Name]

[Address]

[Phone Number]

I declare under penalty of perjury that (1) the person who signed this advance health-care directive is personally known

to us, or that the signer’s identity was proven to us by convincing evidence, (2) that the signer acknowledged this

advance directive in my presence, (3) that the individual appears to be of sound mind and under no duress, fraud, or

undue influence, (4) that we are not a person appointed as an agent by this advance directive, (5) that we are not the

individual’s health-care provider, an employee of the individual’s health-care provider, the operator or employee of a

community-care facility, nor the operator or employee of a residential-care facility for the elderly. We further declare

that we are not related to the signer of this advance health care directive by blood, marriage, domestic partnership or

adoption, and, to the best of my knowledge, we are not entitled to any part of the estate of the signer when he or she

dies.

(Date)

(Witness Signature)

(Address)

(Print Name of Witness)

(City)

(State)

(Date)

(Witness Signature)

(Address)

(Print Name of Witness)

(City)

(State)

State of Georgia

County of\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This instrument was acknowledged before me this \_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_ by [Name].

\_\_\_\_ Personally Known

\_\_\_\_ Produced Identification

Type and # of ID \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Notary Signature)

(Seal)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Notary name typed, stamped or printed)

Notary Public, State of Georgia

**Primary Care Physician**

[Physician’s Name]

[Address]

[Phone Number(s)]

**Medical / Dental / Vision / Prescription Insurance:**

[Insurance Name] – card is in my wallet