Utah Advance Health Care Directive

Pursuant to Utah Code Sections 75-2a-100 et seq.

Part I:	***Allows you to name another person to make health care decisions for you when you cannot make decisions or speak for yourself.***
Part II:	***Allows you to record your wishes about health care in writing.***
Part III:	***Tells you how to revoke or change this directive.***
Part IV:	***Makes your directive legal.***

My Personal Information

Name: _____

Address: _____

Address: _____

Telephone: (_____) _____ Cell Phone: (_____) _____

Birth Date: _____

Part I: My Agent (*Health Care Power of Attorney*)

A: No Agent

If you do not want to name an agent, initial the box, below, then go to Part II; do not name an agent in B. or C. below. You are not required to name an agent, and no one can force you to name an agent.

☐ **I do not want to choose an agent.**

B: My Agent

Agent's Name: _____

Street Address: _____

City, State, Zip: _____

Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____

C: My Alternate Agent

This person will serve as your agent if your agent is unable or unwilling to serve

Agent's Name: _____

Street Address: _____

City, State, Zip: _____

Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____

Part I: My Agent (*continued*)

D: Agent's Authority

If I cannot make decisions or speak for myself, my agent has the power to make any health care decision I could have made, such as, but not limited to:

- Consent to, refuse, or withdraw any health care. This may include care to prolong my life, such as food and fluids by tube, antibiotics, CPR (cardiopulmonary resuscitation), and dialysis, and mental health care, such as convulsive therapy and psychoactive medications. This authority is subject to any limits in paragraph F of this section and in Part II of this directive.
- Hire and fire health care providers.
- Ask questions and get answers from health care providers.
- Consent to admission or transfer to a health care provider or facility, including a mental health facility, subject to the limits in paragraphs E or F of this section.
- Get copies of my medical records.
- Ask for consultations or second opinions.

My agent cannot force health care against my will, even if a physician has found that I lack health care decision making capacity.

E: Other Authority

My agent has the powers below ONLY IF I initial above "YES" next to the statement. I authorize my agent to:

_____ YES _____ NO Get copies of my medical records at any time, even when I can speak for myself.

_____ YES _____ NO Admit me to a licensed health care facility, such as a hospital, nursing home, assisted living, or other facility for long-term placement other than convalescent or recuperative care.

F: Limits/Expansion of Authority

I wish to limit or expand the powers of my health care agent:

_____

G: Nomination of Guardian

Even though appointing an agent should help you to avoid a guardianship, a guardianship may still be necessary. Initial above "YES" if you want the court to appoint your agent to serve as your guardian, if a guardianship is ever necessary.

_____ YES _____ NO I, being of sound mind and not acting under duress, fraud, or other undue influence, do hereby nominate my agent, or, if my agent is unable or unwilling to serve, I nominate my alternate agent to serve as my guardian in the event that, after the date of this instrument, I become incapacitated.

H: Consent to Participate in Medical Research

_____ YES _____ NO I authorize my agent to consent to my participation in medical research or clinical trials, even if I will not benefit from the results.

Box I: Organ Donation

_____ YES _____ NO If I have not otherwise agreed to organ donation, my agent may consent to the donation of my organs for the purpose of organ transplantation.

Part II: My Health Care Wishes (*Living Will*)

I want my health care providers to follow the instructions I give them when I am being treated, even if my instructions conflict with these or other advance directives. My health care providers should always provide health care to keep me as comfortable and functional as possible.

Choose only one *of the following options by placing your initials before the numbered statement.* ***Do not initial more than one option****. If you do not wish to document end-of-life wishes, initial Option 4. You may draw a line through the options that you are not choosing.*

Option 1

_____ **Initial**

I choose to let my agent decide. I have chosen my agent carefully. I have talked with my agent about my health care wishes. I trust my agent to make the health care decisions for me that I would make under the circumstances.

Other: _____

_____

Option 2

_____ **Initial**

I choose to prolong life. Regardless of my condition or prognosis, I want my health care team to try to prolong my life as long as possible within the limits of generally accepted health care standards.

Other: _____

_____

Option 3

_____ **Initial**

I choose not to receive care for the purpose of prolonging life, including food and fluids by tube, antibiotics, CPR, or dialysis being used to prolong my life. I always want comfort care and routine medical care that will keep me as comfortable and functional as possible, even if that care may prolong my life.

If you choose this option, you must also choose either (a) or (b), below.

_____ **Initial**

(a) I put no limit on the ability of my health care provider or agent to withdraw life-sustaining care.
Go to next page. Do not choose options below.

_____ **Initial**

(b) My health care provider should decline to provide life-sustaining care if at least one of the initialed conditions is met:
You must initial at least one of the options below. You may choose more than one condition.

Option 3 Part (b)

	I have a progressive illness that will cause death
	I am close to death and I am unlikely to recover
	I cannot communicate and it is unlikely that my condition will improve
	I do not recognize my friends or family and it is unlikely that my condition will improve
	I am in a persistent vegetative state

Other: _____

_____

Option 4

_____ **Initial**

I do not wish to express preferences about health care wishes in this directive.

Other: _____

_____

Name: _____

Additional instructions about your health care wishes:

_____

_____

Part III: Revoking or Changing a Directive

I may revoke or change this directive by:

1. Writing "void" across the form, burning, tearing, or otherwise destroying or defacing this document or directing another person to do the same on my behalf;
2. Signing a written revocation of the directive, or directing another person to sign a revocation on my behalf;
3. Stating that I wish to revoke in the presence of a witness age 18 years of age or older, who will not be appointed agent in a substitute directive and who will not become a default surrogate if the directive is revoked, and who signs and dates a written document confirming my statement; or
4. Drafting a new directive. (***If you sign a new directive, the most recent directive applies.)***

Part IV: Making the Document Legal

I sign this directive voluntarily. I understand the choices I have made, and declare that I am emotionally and mentally competent to make this directive. My signature on this form revokes any living will or power of attorney form naming a health care agent that I have completed in the past.

_____
Date

_____
Signature

_____
City, County, and State of Residence

I have witnessed the signing of this directive, I am 18 years of age or older, and:

1. I am not related to the declarant by blood or marriage;
2. I am not entitled to any portion of the declarant's estate according to the laws of intestate succession of this state or under any will or codicil of the declarant;
3. I am not the beneficiary of a life insurance policy, trust, qualified plan, property or accounts held in POD, TOD, or co-ownership registration with the right of survivorship;
4. I am not financially responsible for the declarant's support or medical care;
5. I am not a health care provider who is providing care to the declarant or an administrator at a health care facility in which the declarant is receiving care; and
6. I am not the appointed agent or alternate agent.

_____ _____
Signature of Witness Printed Name of Witness

_____ _____ _____ _____
Street Address City State Zip

If the witness is signing to confirm a spoken directive, describe below the circumstances under which the directive was made.

_____

_____

Name: _____

What you should do with this Advance Directive

- Register your Estate Planning Documents for no fee at www.TheUSWillRegistry.Org
- It is suggested that you have your attorney review this form to be assured that it meets all your current state requirements.