

PLANNING METHODS TO CONTROL MEDICAL TREATMENT

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A. WHAT A LIVING WILL CAN AND CANNOT ACCOMPLISH

1. What is a Living Will?

A Living Will enables a person to declare his or her wishes concerning life-prolonging procedures such as extraordinary means and artificial nutrition or hydration. The North Carolina statutory Living Will form, titled a Declaration of a Desire for a Natural Death, is attached hereto as Form 1.

By initialing the appropriate lines on the Living Will form, a person can authorize his or her physician to discontinue extraordinary means and/or artificial nutrition or hydration once the physician has determined the patient is either “terminal and incurable” or in a “persistent vegetative state”.

While most people probably understand the meaning of “persistent vegetative state”, the description of the condition “terminable and incurable” often creates some confusion. As advisors, it may be important for us to clarify for our clients the term “terminal and incurable” as used in the Living Will is not intended to address situations where a patient is still capable of communicating regarding his or her care or whose life is not being prolonged artificially.

The North Carolina form uses the terms “extraordinary means” and “artificial nutrition or hydration” to describe the types of life sustaining procedures that a patient can authorize to be withheld. While the author does not purport to have any medical training, the term “extraordinary means” is commonly interpreted to refer to life support machinery that performs a vital function on behalf of a patient whose body is no longer able to perform such functions on its own. Common examples are a respirator or ventilator. The term “artificial nutrition or hydration” is commonly interpreted to refer to either a feeding tube or any medical technique designed to artificially hydrate a patient’s body. The addition of the term “artificial nutrition or hydration” to the North Carolina form can be attributed in large part to a number of high profile cases throughout the country where individuals have been kept alive with nothing more than a

feeding tube for significant periods of time without the medical likelihood of recovery. The North Carolina legislature apparently decided that individuals should be allowed to make the decision not to be kept alive in this manner.

It is important to point out that the Living Will does not authorize the withholding of pain medication or treatments that are necessary to prevent a patient from enduring unnecessary pain and suffering.

2. What does a Living Will can accomplish?

A Living provides a person's physician, family and friends with a written declaration of his or her wishes regarding the use of life support to artificially prolong his or her life. For this reason, a copy of a properly executed Living Will should be provided to a person's physician as well as others who would likely be involved in deciding whether or not to discontinue life support. By stating his or her own wishes concerning life support, the patient's loved ones are relieved from having to decide for themselves what to do should this situation arise.

The North Carolina Secretary of State now provides an online Advance Health Care Directive Registry service for a fee that is currently \$10 per document, which provides access to a copy of a person's Living Will or other health care directives. Upon filing, the client is provided with a card bearing the website and password for easy online access to the client's documents. This service makes it convenient for family, friends and health care providers to access a copy of the patient's Living Will in the event a hard copy is not readably available.

3. Are there limitations on what a Living Will can accomplish?

While a Living Will is important, and in the author's opinion should be executed by all able individuals, it does not provide a guarantee that a person's wishes with respect to life support will be carried out. Although the Living Will makes a person's wishes clear, it does not always prevent disagreement among friends and family members about whether or not life support should be discontinued. It is not uncommon for families to be split on this issue regardless of the wishes of the person whose life is being prolonged. For example, it may be

difficult for some family members to let go of a loved one even though the loved one's wish not to be kept alive artificially is clearly set forth in the Living Will. If all immediate family members are not in agreement on what action should be taken, an attending physician may not be willing to discontinue life support despite a declaration to the contrary by the patient. As a result of physician's fears about a potential lawsuit, the safer approach for the physician where unanimous consent among family members does not exist is to maintain life support until such time as unanimous consent is achieved.

4. How does a Do Not Resuscitate Order (DNR) differ from a Living Will?

While a Living Will may be used to specify a patient's wish to be discontinued from life support if his or her life is being artificially maintained, it will not prevent the patient from being resuscitated in the event the patient is in a state of cardio-respiratory arrest. Physicians and other medical personnel are required to resuscitate and if possible, stabilize a patient absent proper written authorization requesting that heroic efforts not be undertaken. If a patient desires not to be resuscitated, he or she should execute a Do Not Resuscitate Order, a sample of which is attached hereto as Form 2. The attending physician, the patient and a member of the patient's family must sign the Do Not Resuscitate Order. If the patient has also executed a Health Care Power of Attorney/Health Care Proxy, the Health Care Agent designated by the patient may be authorized to sign the DNR on the patient's behalf.

B. PICKING UP WHERE A LIVING WILL ENDS

1. What is a Health Care Power of Attorney?

A Health Care Power of Attorney, also known as a Health Care Proxy, is a document that allows a person (known as the “principal”) to name a Health Care Agent to make medical decisions on his behalf in the event a physician determines that the principal is no longer able to make or communicate decisions about his own medical care. The creation and execution of a Health Care Proxy is authorized under Article 3, Chapter 32A of the North Carolina General Statutes. The Health Care Proxy gives the principal control over decisions relating to his or her own medical care by designating a Health Care Agent to make these decisions on his or her behalf. The North Carolina statutory Health Care Power of Attorney can be found in section 32A-25 of the North Carolina General Statutes and is attached hereto as Form 3.

The types of decision making power granted to a Health Care Agent are typically broad, and in addition to making decisions about the principal’s medical care include decisions about the continuance of life support, the donation of organs or tissue, an autopsy and the disposition of remains.

2. When does the Health Care Proxy become effective?

A Health Care Proxy shall become effective when and if the physician(s), or in the case of mental health treatment, physician or psychologist, designated by the principal executing the proxy, or by the attending physician if no physician is designated, determines in writing that the principal lacks sufficient understanding or capacity to make or communicate decisions relating to the health care of the principal. According to NCGS section 32A-20, a Health Care Proxy can specify that if the principal does not designate a physician to make this decision based on religious or moral beliefs, the principal can designate an individual to make this decision provided it is in writing and acknowledged before a notary public.

3. Who should serve as Health Care Agent?

NCGS section 32A-18 provides that any competent person who is at least 18 years of age, and who is not engaged in providing health care to the principal for remuneration to the principal, may act as Health Care Agent.

Ideally, the Health Care Agent should be someone with the skills necessary to fully understand the treatment options available and to make an objective decision regarding the treatment that is most appropriate for the principal. If the principal has set forth specific wishes regarding certain types of treatment, organ donation or burial instructions, the principal should be reasonably confident that the chosen Health Care Agent is willing to honor those wishes.

While medical training should not be a pre-requisite for serving as a Health Care Agent since the Agent will always rely to some degree on the diagnosis and recommendations of the treating physician, careful consideration should be given to the existing responsibilities of the prospective Health Care Agent. It is a good idea for the principal to talk to the prospective Health Care Agent in advance of signing to make sure the Agent is comfortable with taking on this new responsibility.

Careful consideration should also be given before naming Co-Health Care Agents. While it is common for the principal to want to give all of his or her children the power to make medical decisions on his or her behalf, the maker of the Health Care Proxy should be mindful of the potential for disagreement among those named. If more than two Co-Health Care Agents are named, the document can specify that the decision of a majority shall prevail. If there is a dissenter, however, a treating physician may still require unanimous consent before taking critical steps such as discontinuing life support.

4. Who should receive a copy of the signed Health Care Proxy?

As with the Living Will, a copy of the executed Health Care Proxy should be given to the principal's physician, the named primary and successor Health Care Agents and others who may have an interest in the client's well being. Also, the Health Care Proxy can be filed with the

North Carolina Secretary of State Advance Health Care Directive Registry for easy online access to this document if a hard copy is unavailable. As with the Living Will, the filing fee is currently \$10 per document.

5. What are the benefits of the Health Care Proxy?

The execution of a Health Care Proxy is beneficial for each of the following reasons:

- i) The Health Care Proxy allows the principal to select one or more individuals who will be responsible for making decisions that directly affect the medical care that he or she receives. Therefore, this document allows the principal to select the person or persons who are best suited to make decisions on his or her behalf.
- ii) If it is necessary for the court to appoint a guardian of the person or a general guardian to make decisions affecting the physical or mental well being of the principal, the execution of a Health Care Proxy allows that principal to nominate his or her Health Care Agent as guardian.
- iii) The Health Care Proxy allows the principal to make specific instructions to his or her Health Care Agent regarding the type of care that he or she wishes to receive or not receive as well as organ donation or the disposition of his or her remains.
- iv) The Health Care Proxy in most situations will reduce the number of people who are authorized to make decisions on the principal's behalf, which in turn will increase the likelihood that decisions can be made in an effective and efficient manner. By designating the person or persons whom he would like to have serve as his Health Care Agent, the principal has given written authority to one or more individuals rather than relying on the entire family to agree on the proper course of action.

- v) The Health Care Proxy also works in conjunction with the principal's Living Will to help ensure that his or her wishes concerning life support are honored.

6. Reliance on the Health Care Proxy by Health Care Providers.

The Health Care Proxy protects the health care provider from decisions made by the Health Care Agent provided the health care provider is not negligent in his or her treatment of the principal. This protection comes from NCGS section 32A-24, which provides that health care providers may rely upon the authority of the Health Care Agent, as granted in the document, absent actual knowledge of revocation. All decisions made by the Health Care Agent pursuant to the Health Care Proxy following the determination of the principal's incapacity shall be given the same effect as if the principal was not incapacitated and was present and acting on his or her own behalf.

7. The Impact of HIPAA on a Health Care Proxy.

Known officially as the Health Insurance Portability and Accountability Act of 1996, 42 USC 1320d and 45 CFR 160-164, HIPAA has had a significant impact on the ability of a third party to obtain a patient's medical information. Before a physician or other health care provider can disclose a patient's medical information to a third party, the patient must sign a written HIPAA release authorizing the release of such information.

Even when a principal has executed a Health Care Proxy, HIPAA can present a problem in situations where it may be necessary for a principal's Health Care Agent to obtain the principal's medical records. This is because the Health Care Proxy does not become effective until the principal's physician determines that the principal lacks sufficient understanding or capacity to make or communicate decisions relating to the principal's medical care. There are often situations, however, where the designated Health Care Agent should have access to the principal's medical records even if the

attending physician still believes that the principal has the capacity to adequately communicate with regard to his or her own medical treatment. This information may be vital to the Health Care Agent's ability to communicate directly with the principal, if not the physician, regarding the type of care the principal should be receiving.

Therefore, it is advisable to give your clients the option of waiving HIPAA under the terms of their Health Care Proxies. This means adding language to the Health Care Proxy that authorizes a principal's Health Care Agent to gain access to the principal's medical records immediately upon execution of the Health Care Proxy. While the attending physician may not authorize the Health Care Agent to make decisions on behalf of the principal until the physician determines that the principal becomes incapacitated, adding a HIPAA waiver to the Health Care Proxy will enable the Health Care Agent to gain access to important medical information and communicate directly with the principal concerning important medical decisions.

The following is suggested language that can be added to the North Carolina Health Care Proxy:

"HIPAA Release Authority

A. HIPAA Release. Notwithstanding any provision herein to the contrary, I authorize my Health Care Agent to request, review, and receive information, verbal or written, regarding my physical or mental health, including but not limited to, all medical and hospital records, forms, test results, and to consent to reproduction and disclosure of this information. In this regard, I hereby direct my physicians, dentist, health plan, hospital, clinic, laboratory, pharmacy, or other covered health care provider, any insurance company, the Medical Information Bureau, Inc., and any other 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 and any and all other health care providers to honor the requests and directives of my Health Care Agent and to give, disclose and release to my Health Care Agent, without restriction, all of my individually identifiable health information and medical records regarding any past present or future medical or mental health condition, including all information relating to the diagnosis and treatment of STD's, mental illness, and drug or alcohol abuse. I intend for my Health Care Agent

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.

B. Effectiveness of Authority. The authority given my Health Care Agent hereunder shall supersede any prior agreement I may have made with my health care providers to restrict access to or disclosure of my individually identifiable health information.

C. Effective Date. Notwithstanding Section 2 of this Health Care Power of Attorney, the provisions contained in this paragraph shall be effective immediately, and without limitation, and shall remain in effect until revoked by me in a written, notarized statement delivered to my Health Care Agent and my attending physician.

D. Waiver of Privacy Rights. I acknowledge that I am, by executing this Health Care Power of Attorney, waiving certain privacy rights provided to me under state and federal law and the provisions hereunder specifically apply to any and all information governed by the Health Insurance Portability and Accountability Act of 1996 (also known as HIPAA), 42 USC 1320d and 45 CFR 160-164.”

C. PATIENT BILL OF RIGHTS

1. Overview:

On March 26, 1997, President Clinton created the Advisory Commission on Consumer Protection and Quality in the Health Care Industry and charged it with recommending such measures as may be necessary to promote and assure health care quality and protect both consumers and workers in the health care system. In so doing, President Clinton asked the Commission to develop a "Patients' Bill of Rights" in health care.

The Commission's Final Report, "Quality First: Better Health Care for All Americans," was issued in March 1998.

A version of the Patients Bill of Rights was eventually passed into law at the federal and state level.

In addition, a Patient Bill of Rights has evolved and is currently embraced in some form by most hospitals and other medical facilities across the country as well as by government health care programs such as Medicaid and Medicare. Provisions may vary slightly, but in most cases include those outlined in Section 2 Summary of Commission's Report.

2. Summary of Commission's Report.

The Patients' Bill of Rights and Responsibilities has three primary goals: i) to strengthen consumer confidence that the health care system is fair and responsive to consumer needs; ii) to reaffirm the importance of a strong relationship between patients and their health care providers; and iii) to reaffirm the critical role consumers play in safeguarding their own health.

In addition to establishing primary goals, the Commission articulated seven sets of rights and stressed the importance of patients taking greater responsibility for protecting and maintaining their own health.

The patients rights summarized below appear in the summary section of the Commission's Report.

The Right to Information. Patients have the right to receive accurate, easily understood information to assist them in making informed decisions about their health plans, facilities and professionals.

The Right to Choose. Patients have the right to a choice of health care providers that are sufficient to assure access to appropriate high-quality health care including giving women access to qualified specialists such as obstetrician-gynecologists and giving patients with serious medical conditions and chronic illnesses access to specialists.

Access to Emergency Services. Patients have the right to access emergency health services when and where the need arises. Health plans should provide payment when a patient presents himself/herself to any emergency department with acute symptoms of sufficient severity "including severe pain" that a "prudent layperson" could reasonably expect the absence of medical attention to result in placing that consumer's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

Being a Full Partner in Health Care Decisions. Patients have the right to fully participate in all decisions related to their health care. Consumers who are unable to fully participate in treatment decisions have the right to be represented by parents, guardians, family members, or other conservators. Additionally, provider contracts should not

contain any so-called "gag clauses" that restrict health professionals' ability to discuss and advise patients on medically necessary treatment options.

Care Without Discrimination. Patients have the right to considerate, respectful care from all members of the health care industry at all times and under all circumstances. Patients must not be discriminated against in the marketing or enrollment or in the provision of health care services, consistent with the benefits covered in their policy and/or as required by law, based on race, ethnicity, national origin, religion, sex, age, current or anticipated mental or physical disability, sexual orientation, genetic information, or source of payment.

The Right to Privacy. Patients have the right to communicate with health care providers in confidence and to have the confidentiality of their individually-identifiable health care information protected. Patients also have the right to review and copy their own medical records and request amendments to their records.

The Right to Speedy Complaint Resolution. Patients have the right to a fair and efficient process for resolving differences with their health plans, health care providers, and the institutions that serve them, including a rigorous system of internal review and an independent system of external review.

D. ANATOMICAL GIFTS

Given the need for anatomical gifts for a variety of health related purposes, and an interest in making such gifts by members of the general public, North Carolina has adopted the Uniform Anatomical Gift Act, which can be found in Sections 130A-402 to 130A-412.2 of the General Statutes.

1. Donors: A “Donor” is simply the person who may make an anatomical Gift. Acceptable Donors are spelled out in NCGS section 130A-404.

A donor can be either a person of sound mind who is at least 18 years of age, or a family member, a Health Care Agent or guardian in the absence of actual notice of contrary indications made by the decedent. If the Donor is the decedent as opposed to a family member, Health Care Agent or guardian, and if the Donor has executed the proper documentation to make a gift of organs or tissue, such gift shall become irrevocable upon the Donor’s death. Neither the Donor’s family, Health Care Agent nor guardian may refuse to honor the gift or interfere with the procurement process.

The Donor need not be the decedent. NCGS section 130A-404(b) provides a list of persons, listed by order of priority, who may make gifts of all or part of the decedent’s body. The order of priority is as follows: 1) Spouse, 2) adult child, 3) either parent, 4) the guardian of the person at the time of the ward’s death or 5) any other person authorized or under obligation to dispose of the body. The decision to donate all or part of the decedent’s body may be made in the order stated when persons in prior classes are not available at the time of death, but only in the absence of actual notice of the contrary intentions of the decedent, or actual notice of opposition by a member of the same or prior class.

Authorized Donor’s may make the gift either after or immediately before the decedent’s death except a gift by the guardian of ward’s person may make such a gift at any time during the guardianship. In such case, the gift shall become effective upon the death of the ward unless the guardianship is terminated before death. A donation by the guardian shall be in the form of a statement signed by the guardian and filed with the clerk of court.

2. Donees: The list of acceptable Donees of a human body or it’s parts are set forth in NCGS section 130A-405, and includes hospitals, surgeons, physicians, accredited medical or dental schools, organ banks or storage facilities, and specified individuals in need of therapy or transplantation.

If the Donor does not specify a Donee, the gift may be accepted by the attending physician as Donee upon death of the Donor. If the gift is made to a Donee who is not available at the time and place of death of the Donor, the attending physician upon or following death, in the absence of any express indication that the Donor desired otherwise, may accept the gift as Donee.

3. Manner of Making Gifts: Acceptable ways to make gifts of all or part of the body are set forth in NCGS section 130A-406. Any of the following documents can be used by a Donor:

- i. Gifts under a Will: The gift shall become effective immediately upon the death of the testator without waiting for probate.
- ii. Gift by documents other than a Will: Other documents are typically used to specify a Donor's intentions to donate his or her body or body parts. Common documents used for this purpose include a Health Care Power of Attorney, an Anatomical Gift form, a sample of which is attached hereto as Form 4 or a card carried by the Donor. This document must be signed by the Donor in the presence of two witnesses who must sign in the Donor's presence. If the Donor cannot sign, this document may be signed on the Donor's behalf at his or her direction in the presence of two witnesses who must sign the document in the Donor's presence.
- iii. Gift's made by a Donor other than the decedent may be made by a document signed by the Donor or made by the Donor's telegraphic, recorded telephonic, or other recorded message. As indicated above, a guardian of the person who makes an anatomical gift prior to the ward's death shall make the gift by a document signed by the guardian and filed with the clerk of court having jurisdiction over the guardian.

4. Delivery of Document of Gift: NCGS section 130A-407 provides that the document making the gift may be delivered to the Donee at any time although

delivery is not necessary to validate the gift. An executed copy of the gift document may be deposited with a hospital, bank or other storage facility, or a registry that accepts the document for safekeeping and/or to facilitate necessary donation procedures after death. The office of the North Carolina Secretary of State now provides an online registry service for a fee of \$10 per document. The Donor can then carry a card with the record number and password for easy access to the gift document by the Donee.

5. Amendment or Revocation of the Gift: NCGS section 130A-408 provides that the Donor can amend or revoke his or her gift in a variety of ways, including i) a signed amendment or revocation delivered to the Donee, ii) an oral statement made in the presence of two witnesses and communicated to the Donee, iii) a statement made during a terminal illness or injury addressed to the attending physician and communicated to the Donee or iv) a signed statement found on the individual or in his or her papers, which is made known to the Donee.

Of course if the document creating the gift has not yet been delivered to the Donee and has not been filed with a medical facility, storage bank, or registry, it may be revoked or amended as specified above or by modification or destruction of the document.

If the gift document has been filed with a medical facility, storage bank or registry, but has not been delivered to the specific Donee, a written document revoking or amending the gift should also be filed with the medical facility, storage bank or registry.

6. Human Tissue Donation Program: Recognizing the increasing need of tissue for transplantation, research and medical education purposes, the North Carolina General Assembly has established a coordinated human tissue donation program to facilitate the acquisition and distribution of human tissue to promote public health. More information about this program can be found in NCGS section 130A-413.

FORM 1

NORTH CAROLINA

DECLARATION OF A DESIRE FOR A

_____ **COUNTY**

NATURAL DEATH

I, _____, being of sound mind, desire that, as specified below, my life not be prolonged by extraordinary means or by artificial nutrition or hydration if my condition is determined to be terminal and incurable or if I am diagnosed as being in a persistent vegetative state. I am aware and understand that this writing authorizes a physician to withhold or discontinue extraordinary means or artificial nutrition or hydration, in accordance with my specifications set forth below:

(Initial any of the following, as desired):

_____ If my condition is determined to be terminal and incurable, I authorize the following:

_____ My physician may withhold or discontinue extraordinary means.

_____ In addition to withholding or discontinuing extraordinary means if such means are necessary, my physician may withhold or discontinue either artificial nutrition or hydration, or both.

_____ If my physician determines that I am in a persistent vegetative state, I authorize the following:

_____ My physician may withhold or discontinue extraordinary means.

_____ In addition to withholding or discontinuing extraordinary means if such means are necessary, my physician may withhold or discontinue either artificial nutrition or hydration, or both.

This the ___ day of _____, 2005.

I hereby state that the declarant, _____, being of sound mind signed the above declaration in my presence and that I am not related to the declarant by blood or marriage and that I do not know or have a reasonable expectation that I would be entitled to any

portion of the estate of the declarant under the existing will or codicil of the declarant or as an heir under the Intestate Succession Act if the declarant died on this date without a will. I also state that I am not the declarant's attending physician or an employee of the declarant's attending physician, or an employee of a health facility in which the declarant is a patient or an employee of a nursing home or any group-care home where the declarant resides. I further state that I do not now have any claim against the declarant.

Witness

Witness

CERTIFICATE

I, _____, Notary Public for _____ County hereby certify that _____, the declarant, appeared before me and swore to me and to the witnesses in my presence that this instrument is his Declaration of a Desire for a Natural Death, and that he had willingly and voluntarily made and executed it as his free act and deed for the purposes expressed in it.

I further certify that _____ and _____, witnesses, appeared before me and swore that they witnessed _____, declarant, sign the attached declaration, believing him to be of sound mind; and also swore that at the time they witnessed the declaration (i) they were not related within the third degree to the declarant or to the declarant's spouse, and (ii) they did not know or have a reasonable expectation that they would be entitled to any portion of the estate of the declarant upon the declarant's death under any will of the declarant or codicil thereto then existing or under the Intestate Succession Act as it provides at this time, and (iii) they were not a physician attending the declarant or an employee of a health facility in which the declarant resided, and (iv) they did not have a claim against the declarant. I further certify that I am satisfied as to the genuineness and due execution of the declaration.

This the ___ day of _____, 2005.

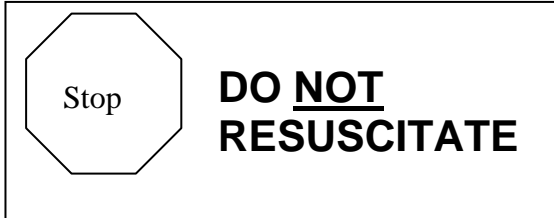
Notary Public

My Commission Expires: _____

FORM 2

Out of Facility Order

Effective Date: _____



Expiration Date: _____
(not to exceed one year from the effective date)

OUT OF FACILITY ORDER

Patient's Full Legal Name: _____

Attending Physician's Statement

I, the undersigned, state that I am the attending physician of the patient named above, that the patient is [check 1,2or3]:

- 1. incurably and terminally ill without an advance care document and [check (a) or (b)]
 - (a) comatose with no reasonable possibility of returning to a cognitive sapient state, or
 - (b) mentally incompetent [requires signature of responsible person and notary public, see reverse]
- 2. incurably and terminally ill with a written patient advance care document and [check (a) or (b)]
 - (a) comatose with no reasonable possibility of returning to a cognitive sapient state, or
 - (b) mentally incompetent [requires attachment of a copy of advance care document]
- 3. incurably and terminally ill and mentally competent [requires signature of patient and notary public, see reverse]

I do hereby direct any and all medical personnel, commencing on the effective date noted above and expiring on the expiration date noted above, that in the event of cardiorespiratory arrest of the patient, efforts at cardiopulmonary resuscitation of the patient should not be initiated. This includes cardiac compression, endotracheal intubation and defibrillation. Other medically indicated and comforting care and therapy should be initiated.

Signature of Attending Physician

Telephone Number in case of Emergency

Printed Name

Recertification

New Effective date: _____

Signature of Attending Physician

New Expiration date: _____

Patient's Statement

I, the undersigned, hereby direct that in the event of my cardiorespiratory arrest efforts at cardiopulmonary resuscitation should not be initiated. I understand that I may revoke these directions at any time.

Signature of Patient

State of North Carolina
County of Wake

I, _____, a Notary Public in and for the aforesaid jurisdiction, hereby certify that the Patient's Statement was executed before me by _____, this ____ day of _____, _____.

Notary Public

My Commission Expires _____
[Notarial Seal]

Concurrence of Responsible Person

I, the undersigned, hereby certify that I bear the following relationship to and am the proper responsible person to represent the desires of the patient:

Relationship: _____
(spouse, guardian, next of kin, attending physician when no other responsible person available, etc.)

I am not aware of the presence of an advance care document of the patient and concur with the attending physician that in the event of cardiorespiratory arrest, efforts at cardiopulmonary resuscitation of the patient should not be initiated. I understand that I may revoke this concurrence at any time.

Signature of Responsible Person

State of North Carolina
County of _____

I, _____, a Notary Public in and for the aforesaid jurisdiction, hereby certify that the Concurrence of Responsible Person was executed before me by _____, in his/her capacity as Responsible Person for _____, this _____ day of _____, _____.

Notary Public

My Commission Expires: _____

[Notarial Seal]

FORM 3

NORTH CAROLINA

HEALTH CARE POWER

OF

_____ COUNTY

ATTORNEY

(NOTICE: THIS DOCUMENT GIVES THE PERSON YOU DESIGNATE YOUR HEALTH CARE AGENT BROAD POWERS TO MAKE HEALTH CARE DECISIONS, INCLUDING MENTAL HEALTH TREATMENT DECISIONS, FOR YOU. EXCEPT TO THE EXTENT THAT YOU EXPRESS SPECIFIC LIMITATIONS OR RESTRICTIONS ON THE AUTHORITY OF YOUR HEALTH CARE AGENT, THIS POWER INCLUDES THE POWER TO CONSENT TO YOUR DOCTOR NOT GIVING TREATMENT OR STOPPING TREATMENT NECESSARY TO KEEP YOU ALIVE, ADMIT YOU TO A FACILITY, AND ADMINISTER CERTAIN TREATMENTS AND MEDICATIONS. THIS POWER EXISTS ONLY AS TO THOSE HEALTH CARE DECISIONS FOR WHICH YOU ARE UNABLE TO GIVE INFORMED CONSENT.)

THIS FORM DOES NOT IMPOSE A DUTY ON YOUR HEALTH CARE AGENT TO EXERCISE GRANTED POWERS, BUT WHEN A POWER IS EXERCISED, YOUR HEALTH CARE AGENT WILL HAVE TO USE DUE CARE TO ACT IN YOUR BEST INTERESTS AND IN ACCORDANCE WITH THIS DOCUMENT. FOR MENTAL HEALTH TREATMENT DECISIONS, YOUR HEALTH CARE AGENT WILL ACT ACCORDING TO HOW THE HEALTH CARE AGENT BELIEVES YOU WOULD ACT IF YOU WERE MAKING THE DECISION. BECAUSE THE POWERS GRANTED BY THIS DOCUMENT ARE BROAD AND SWEEPING, YOU SHOULD DISCUSS YOUR WISHES CONCERNING LIFE-SUSTAINING PROCEDURES, MENTAL HEALTH TREATMENT AND OTHER HEALTH CARE DECISIONS WITH YOUR HEALTH CARE AGENT.

USE OF THIS FORM IN THE CREATION OF A HEALTH CARE POWER OF ATTORNEY IS LAWFUL AND IS AUTHORIZED PURSUANT TO NORTH CAROLINA LAW. HOWEVER, USE OF THIS FORM IS AN OPTIONAL AND NONEXCLUSIVE METHOD FOR CREATING A HEALTH CARE POWER OF ATTORNEY AND NORTH CAROLINA LAW DOES NOT BAR THE USE OF ANY OTHER OR DIFFERENT FORM OF POWER OF ATTORNEY FOR HEALTH CARE THAT MEETS THE STATUTORY REQUIREMENTS.)

1. Designation of health care agent.

I, _____, being of sound mind, hereby appoint:

Name: _____

as my health care attorney-in-fact (herein referred to as my "health care agent") to act for me and in my name (in any way I could act in person) to make health care decisions for me as authorized in this document.

If the person named as my health care agent is not reasonably available or is unable or unwilling to act as my agent, then I appoint the following persons (each to act alone and successively, in the order named) to serve in that capacity:

A. Name: _____

B. Name: _____

Each successor health care agent designated shall be vested with the same power and duties as if originally named as my health care agent.

2. Effectiveness of appointment.

(NOTICE: THIS HEALTH CARE POWER OF ATTORNEY MAY BE REVOKED BY YOU AT ANY TIME IN ANY MANNER BY WHICH YOU ARE ABLE TO COMMUNICATE YOUR INTENT TO REVOKE TO YOUR HEALTH CARE AGENT AND YOUR ATTENDING PHYSICIAN.)

Absent revocation, the authority granted in this document shall become effective when and if my attending physician or physicians determine that I lack sufficient understanding or capacity to make or communicate decisions relating to my health care and will continue in effect during my incapacity, until my death. This determination shall be made by the following physician or physicians. For decisions related to mental health treatment, this determination shall be made by the following physician or eligible psychologist. (You may include here a designation of your choice, including your attending physician or eligible psychologist, or any other physician or eligible psychologist. You may also name two or more physicians or eligible psychologists, if desired, both of whom must make this determination before the authority granted to the health care agent becomes effective.):

_____.

3. General statement of authority granted.

Except as indicated in section 4 below, I hereby grant to my health care agent named above full power and authority to make health care decisions, including mental health treatment decisions, on my behalf, including, but not limited to, the following:

A. To request, review, and receive any information, verbal or written, regarding my physical or mental health, including, but not limited to, medical and hospital records, and to consent to the disclosure of this information;

B. To employ or discharge my health care providers;

C. To consent to and authorize my admission to and discharge from a hospital, nursing or convalescent home, or other institution;

D. To consent to and authorize my admission to and retention in a facility for the care or treatment of mental illness;

E. To consent to and authorize the administration of medications for mental health treatment and electroconvulsive treatment (ECT) commonly referred to as “shock treatment”;

F. To give consent for, to withdraw consent for, or to withhold consent for, X ray, anesthesia, medication, surgery, and all other diagnostic and treatment procedures ordered by or under the authorization of a licensed physician, dentist, or podiatrist. This authorization specially includes the power to consent to measures for relief of pain.

G. To authorize the withholding or withdrawal of life-sustaining procedures when and if my physician determines that I am terminally ill, permanently in a coma, suffer severe dementia, or am in a persistent vegetative state. Life-sustaining procedures are those forms of medical care that only serve to artificially prolong the dying process and may include mechanical ventilation, dialysis, antibiotics, artificial nutrition and hydration, and other forms of medical treatment which sustain, restore or supplant vital bodily functions. Life-sustaining procedures do not include care necessary to provide comfort or alleviate pain.

I DESIRE THAT MY LIFE NOT BE PROLONGED BY LIFE SUSTAINING PROCEDURES IF I AM TERMINALLY ILL, PERMANENTLY IN A COMA, SUFFER SEVERE DEMENTIA, OR AM IN A PERSISTENT VEGETATIVE STATE.

H. To exercise any right I may have to make a disposition of any part or all of my body for medical purposes, to donate my organs, to authorize an autopsy, and to direct the disposition of my remains.

I. To take any lawful actions that may be necessary to carry out these decisions, including the granting of release of liability to medical providers.

4. HIPAA Release Authority

A. HIPAA Release. Notwithstanding any provision herein to the contrary, I authorize my health care agent to request, review, and receive information, verbal or written, regarding my physical or mental health, including but not limited to, all medical

and hospital records, forms, test results, and to consent to reproduction and disclosure of this information. In this regard, I hereby direct my physicians, dentist, health plan, hospital, clinic, laboratory, pharmacy, or other covered health care provider, any insurance company, the Medical Information Bureau, Inc., and any other 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 and any and all other health care providers to honor the requests and directives of my health care agent and to give, disclose and release to my health care agent, without restriction, all of my individually identifiable health information and medical records regarding any past present or future medical or mental health condition, including all information relating to the diagnosis and treatment of STD's, mental illness, and drug or alcohol abuse. I intend for my health care agent 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.

B. Effectiveness of Authority. The authority given my health care agent hereunder shall supersede any prior agreement I may have made with my health care providers to restrict access to or disclosure of my individually identifiable health information.

C. Effective Date. Notwithstanding Section 2 of this Health Care Power of Attorney, the provisions contained in this paragraph shall be effective immediately, and without limitation, and shall remain in effect until revoked by me in a written, notarized statement delivered to my health care agent and my attending physician.

D. Waiver of Privacy Rights. I acknowledge that I am, by executing this Health Care Power of Attorney, waiving certain privacy rights provided to me under state and federal law and the provisions hereunder specifically apply to any and all information governed by the Health Insurance Portability and Accountability Act of 1996 (also known as HIPAA), 42 USC 1320d and 45 CFR 160-164.

5. Special provisions and limitations.

(NOTICE: THE ABOVE GRANT OF POWER IS INTENDED TO BE AS BROAD AS POSSIBLE SO THAT YOUR HEALTH CARE AGENT WILL HAVE AUTHORITY TO MAKE ANY DECISIONS YOU COULD MAKE TO OBTAIN OR TERMINATE ANY TYPE OF HEALTH CARE. IF YOU WISH TO LIMIT THE SCOPE OF YOUR HEALTH CARE AGENT'S POWERS, YOU MAY DO SO IN THIS SECTION.)

A. In exercising the authority to make health care decision on my behalf, the authority of my health care agent is subject to the following special provisions and limitations (Here you may include any specific limitations you deem appropriate such as: your own definition of when life-

sustaining treatment should be withheld or discontinued, or instructions to refuse any specific types of treatment that are inconsistent with your religious beliefs, or unacceptable to you for any other reason.):

B. In exercising the authority to make mental health decisions on my behalf, the authority of my health care agent is subject to the following special provisions and limitations (Here you may include any specific limitations you deem appropriate such as: limiting the grant of authority to make only mental health treatment decisions, your own instructions regarding the administration or withholding of psychotropic medications and electroconvulsive treatment (ECT), instructions regarding your admission to and retention in a health care facility for mental health treatment, or instructions to refuse any specific types of treatment that are unacceptable to you):

C. (Notice: This health care power of attorney may incorporate or be combined with an advance instruction for mental health treatment, executed in accordance with Part 2 of Article 3 of Chapter 122C of the General Statutes, which you may use to state your instructions regarding mental health treatment in the event you lack sufficient understanding or capacity to make or communicate mental health treatment decisions. Because your health care agent's decisions about decisions must be consistent with any statements you have expressed in an advance instruction, you should indicate here whether you have executed an advance instruction for mental health treatment:

6. Guardianship provision.

If it becomes necessary for a court to appoint a guardian of my person, I nominate my health care agent acting under this document to be the guardian of my person to serve without bond or security. The guardian shall act consistently with G.S. 35A-1201(a)(5).

7. Reliance of third parties on health care agent.

A. No person who relies in good faith upon the authority of or any representations by my health care agent shall be liable to me, my estate, my heirs, successors, assigns, or personal representatives, for actions or omissions by my health care agent.

B. The powers conferred on my health care agent by this document may be exercised by my health care agent alone, and my health care agent's signature or act under the authority granted in this document may be accepted by persons as fully authorized by me with the same force and effect as if I were personally present, competent, and acting on my own behalf. All

acts performed in good faith by my health care agent pursuant to this power of attorney are done with my consent and shall have the same validity and effect as if I were present and exercised the powers myself and shall inure to the benefit of and bind me, my estate, my heirs, successors, assigns, and personal representatives. The authority of my health care agent pursuant to this power of attorney shall be superior to and binding upon my family, relatives, friends, and others.

8. Miscellaneous provisions.

A. I revoke any prior health care power of attorney.

B. My health care agent shall be entitled to sign, execute, deliver, and acknowledge any contract or other document that may be necessary, desirable, convenient, or proper in order to exercise and carry out any of the powers described in this document and to incur reasonable costs on my behalf incident to the exercise of these powers; provided, however, that except as shall be necessary in order to exercise the powers described in this document relating to my health care, my health care agent shall not have any authority over my property or financial affairs.

C. My health care agent and my health care agent's estate, heirs, successors, and assigns are hereby released and forever discharged by me, my estate, my heirs, successors, and assigns and personal representatives from all liability and from all claims or demands of all kinds arising out of the acts or omissions of my health care agent pursuant to this document, except for willful misconduct or gross negligence.

D. No act or omission of my health care agent, or of any other person, institution, or facility acting in good faith in reliance on the authority of my health care agent pursuant to this health care power of attorney shall be considered suicide, nor the cause of my death for any civil or criminal purposes, nor shall it be considered unprofessional conduct or as lack of professional competence. Any person, institution, or facility against whom criminal or civil liability is asserted because of conduct authorized by this health care power of attorney may interpose this document as a defense.

9. Signature of principal.

By signing here, I indicate that I am mentally alert and competent, fully informed as to the contents of this document, and understand the full import of this grant of powers to my health care agent.

DATE

10. Signatures of Witnesses.

I hereby state that the Principal, _____, being of sound mind, signed the foregoing health care power of attorney in my presence, and that I am not

related to the principal by blood or marriage, and I would not be entitled to any portion of the estate of the principal under any existing will or codicil of the principal or as an heir under the Intestate Succession Act, if the principal died on this date without a will. I also state that I am not the principal's attending physician, nor an employee of the principal's attending physician, nor an employee of the health facility in which the principal is a patient, nor an employee of a nursing home or any group care home where the principal resides. I further state that I do not have any claim against the principal.

Witness: _____ Date: _____

Witness: _____ Date: _____

STATE OF NORTH CAROLINA
COUNTY OF _____

CERTIFICATE

I, _____, a Notary Public for _____ County, North Carolina, hereby certify that _____ appeared before me and swore to me and to the witnesses in my presence that this instrument is a health care power of attorney, and that he willingly and voluntarily made and executed it as his free act and deed for the purposes expressed in it.

I further certify that _____ and _____, witnesses, appeared before me and swore that they witnessed _____ sign the attached health care power of attorney, believing him to be of sound mind; and also swore that at the time they witnessed the signing (i) they were not related within the third degree to him or his spouse, and (ii) they did not know nor have a reasonable expectation that they would be entitled to any portion of his estate upon his death under any will or codicil thereto then existing or under the Intestate Succession Act as it provided at that time, and (iii) they were not a physician attending him, nor an employee of an attending physician, nor an employee of a health facility in which he was a patient, nor an employee of a nursing home or any group-care home in which he resided, and (iv) they did not have a claim against him. I further certify that I am satisfied as to the genuineness and due execution of the instrument.

This the ____ day of _____, 2005.

Notary Public

My commission expires: _____

(A COPY OF THIS FORM SHOULD BE GIVEN TO YOUR HEALTH CARE AGENT AND ANY ALTERNATE NAMED IN THIS POWER OF ATTORNEY, AND TO YOUR PHYSICIAN AND FAMILY MEMBERS.)

FORM 4

Anatomical Gift

In the hope that I may help others, I, _____, hereby make this anatomical gift, if medically applicable, to take effect upon my death.

Personal Information

Full Name

Social Security No.

Street Address

Telephone Number

City, State, Zip Code

Next of Kin

Relationship

Street Address

Telephone Number

City, State, Zip Code

I GIVE:

Any needed organs or parts _____

Only the following organs or parts:

I have previously signed with a medical school.

Yes If yes, name of school:

I have the following special wishes concerning my anatomical gift:

I authorize the physician listed below to furnish my attending physician any pertinent medical information in the event of my death.

Physician's Name

Telephone Number

Street Address

City, State, Zip Code

I have signed my Anatomical Gift on _____, 2005, as witnessed below:

DONOR

WITNESS

WITNESS