

**MARYLAND ADVANCE DIRECTIVE:**

I, \_\_\_\_\_, residing in Calvert County, Maryland, do hereby declare this document to serve as my Advance Directive, including the appointment of my health care agent and instructions regarding health care decisions. Any prior Advance Directives or appointment of health care agents executed by me prior hereto are revoked.

**PART I: SELECTION OF HEALTH CARE AGENT**

**A. Selection of Primary Agent**

I select the following individual as my agent to make health care decision for me:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Numbers: \_\_\_\_\_

**B. Selection of Back-up Agents**

(Optional; form valid if left blank)

1. If my primary agent cannot be contacted in time or for any reason is unavailable or unable or unwilling to act as my agent, then I select the following person to act in this capacity:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Numbers: \_\_\_\_\_

2. If my primary agent and my first back-up agent cannot be contacted in time or for any reason are unavailable or unable or unwilling to act as my agent, then I select the following person to act in this capacity:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Numbers: \_\_\_\_\_

**C. Powers and Right of Health Care Agent**

I want my agent to have full power to make health care decisions for me, including the power to:

1. Consent or not to medical procedures and treatments which my doctors offer, including things that are intended to keep me alive, like ventilators and feeding tubes;
2. Decide who my doctor and other health care providers should be; and
3. Decide where I should be treated, including whether I should be in a hospital, nursing home, other medical care facility, or hospice program.
4. I also want my agent to:
  - a. Ride with me in an ambulance if ever I need to be rushed to the hospital; and
  - b. Be able to visit me if I am in a hospital or any other health care facility.

**D. How my Agent is to Decide Specific Issues**

I trust my agent’s judgment. My agent should look first to see if there is anything in Part II of this advance directive that helps decide the issue. Then, my agent should think about the conversations we have had, my religious and other beliefs and values, my personality, and how I handled medical and other important issues in the past. If what I would decide is still unclear, then my agent is to make decisions for me that my agent believes are in my best interest. In doing so, my agent should consider the benefits, burdens, and risks of the choices presented by my doctors.

**E. People My Agent Should Consult**  
(Optional; form valid if left blank)

In making important decision on my behalf, I encourage my agent to consult with the following people. By filling this in, I do not intend to limit the number of people with whom my agent might want to consult or my agent’s power to make decisions.

Name(s)	Telephone Number(s):
_____	_____
_____	_____
_____	_____
_____	_____

**F. In Case of Pregnancy**  
(Optional, for women of child-bearing years only; form valid if left blank)

If I am pregnant, my agent shall follow these specific instructions:

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**G. Access to my Health Information – Federal Privacy Law (HIPAA) Authorization**

1. If, prior to the time the person selected as my agent has power to act under this document, my doctor wants to discuss with that person my capacity to make my own health care decisions, I authorize my doctor to disclose protected health information which relates to that issue.
2. Once my agent has full power to act under this document, my agent may request, receive, and review any information, oral or written, regarding my physical or mental health, including, but not limited to, medical and hospital records and other protected health information, and consent to disclosure of this information.
3. For all purposes related to this document, my agent is my personal representative under the Health Insurance Portability and Accountability Act (HIPAA). My agent may sign, as my personal representative, any release forms or other HIPAA-related materials.

**H. Effectiveness of this Part**

(Read both of these statements carefully. Then, initial **one** only.)

My agent's power is in effect:

\_\_\_\_\_ 1. Immediately after I sign this document, subject to my right to make any decision about my health care if I want and am able to.

**OR**

\_\_\_\_\_ 2. Whenever I am not able to make informed decisions about my health care, either because the doctor in charge of my care (attending physician) decides that I have lost this ability **temporarily**, or my attending physician and a consulting doctor agree that I have lost this ability **permanently**.

**PART II: TREATMENT PREFERENCES (“LIVING WILL”)**

**A. Statement of Goals and Values**  
(Optional: Form valid if left blank)

I want to say something about my goals and values, and especially what’s most important to me during the last part of my life:

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**B. Preference in Case of Terminal Condition**

(If you want to state what your preference is, initial **one** only. If you do not want to state a preference here, cross through the whole section.)

If my doctors certify that my death from a terminal condition is imminent, even if life sustaining procedures are used:

\_\_\_\_ 1. Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means.

**OR**

\_\_\_\_ 2. Keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical means.

**OR**

\_\_\_\_ 3. Try to extend my life for as long as possible, using all available interventions that in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical means.

**C. Preference in Case of Persistent Vegetative State**

(If you want to state what your preferences is, initial one only. If you do not want to state a preference here, cross through the whole section.)

If my doctors certify that I am in a persistent vegetative state, that is, if I am not conscious and am not aware of myself or my environment or able to interact with others, and there is no reasonable expectation that I will ever regain consciousness:

\_\_\_\_ 1. Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means.

**OR**

\_\_\_\_ 2. Keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical means.

**OR**

\_\_\_\_ 3. Try to extend my life for as long as possible, using all available interventions that in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical means.

**D. Preference in Case of End-State Condition**

(If you want to state what your preference is, initial **one** only. If you do not want to state a preference here, cross through the whole section.)

If my doctors certify that I am in an end-stage condition, that is, an incurable condition that will continue in its course until death and that has already resulted in loss of capacity and complete physical dependency:

\_\_\_\_ 1. Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means.

**OR**

\_\_\_\_ 2. Keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical means.

**OR**

\_\_\_\_ 3. Try to extend my life for as long as possible, using all available interventions that in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical means.

**E. Pain Relief**

No matter what my condition, give me the medicine or other treatment I need to relieve pain.

**F. In Case of Pregnancy**

(Optional, for women of child-bearing years only; form valid if left blank)

If I am pregnant, my decision concerning life-sustaining procedures shall be modified as follows:

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**G. Effect of Stated Preferences**

(Read both of these statements carefully. Then, initial **one** only.)

\_\_\_\_ 1. I realize I cannot foresee everything that might happen after I can no longer decide for myself. My stated preferences are meant to guide whoever is making decisions on my behalf and my health care providers, but I authorize them to be flexible in applying these statements if they feel that doing so would be in my best interest.

**OR**

\_\_\_\_ 2. I realize I cannot foresee everything that might happen after I can no longer decide for myself. Still I want whoever is making decisions on my behalf and my health care providers to follow my stated preferences exactly as written, even if they think that some alternative is better.

**PART III: SIGNATURES AND WITNESSES**

By signing below as the Declarant, I indicate that I am emotionally and mentally competent to make this advance directive and that I understand its purpose and effect. I also understand that this document replaces any similar advance directive I may have completed before this date.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

The Declarant signed or acknowledged signing this document in my presence and, based upon personal observations, appears to be emotionally and mentally competent to make this advance directive.

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Telephone Number(s)

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Telephone Number(s)

For Discussion Purposes Only

**AFTER MY DEATH**

I, \_\_\_\_\_, declare that my wishes as specified below be honored after my death.

**PART I: ORGAN DONATION**

(Initial the ones that you want. Cross through any that you do not want.)

Upon my death I wish to donate:

\_\_\_\_\_ Any needed organs, tissues, or eyes.

\_\_\_\_\_ Only the following organs, tissues, or eyes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I authorize the use of my organs, tissues, or eyes:

\_\_\_\_\_ For transplantation

\_\_\_\_\_ For therapy

\_\_\_\_\_ For research

\_\_\_\_\_ For medical education

\_\_\_\_\_ For any purpose authorized by law

I understand that no vital organ, tissue, or eye may be removed for transplantation until after I have been pronounced dead. This document is not intended to change anything about my health care while I am still alive. After death, I authorize any appropriate support measures to maintain the viability for transplantation of my organs, tissues, and eyes until organ, tissue, and eye recovery has been completed. I understand that my estate will not be charged for any costs related to this donation.

**PART II: DONATION OF BODY**

\_\_\_\_\_ After any organ donation indicated in Part I, I wish my body to be donated for use in a medical study program.

**PART III: DISPOSITION OF BODY AND FUNERAL ARRANGEMENTS**

I want the following person to make decisions about the disposition of my body and my funeral arrangements: (Either initial the first or fill in the second.)

\_\_\_\_\_ The health care agent who I named in my advance directive.

**OR**

This person:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number(s): \_\_\_\_\_

If I have written my wishes below, they should be followed. If not, the person I have named should decide based on conversations we have had, my religious or other beliefs and values, my personality, and how I reacted to other peoples' funeral arrangements. My wishes about the disposition of my body and my funeral arrangements are:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PART IV: SIGNATURE AND WITNESSES**

By signing below, I indicate that I am emotionally and mentally competent to make this donation and that I understand the purpose and effect of this document.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

The Donor signed or acknowledged signing the foregoing document in my presence and, based upon personal observation, appears to be emotionally and mentally competent to make this donation.

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Telephone Number(s)

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Telephone Number(s)