



By: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(print name) (Month/Day/Year)

This form contains only a section to select a Health Care Agent adapted from the Maryland Advance Directive Form. The full version of the form can be found online at <http://www.oag.state.md.us/Healthpol/adirective.pdf>.

Selecting a Health Care Agent (or completing a full advance directive) is completely optional. You may use this form or many other versions. No matter what form you use, talk to your family and others close to you about your wishes.

Make sure you give a copy of any completed form to your health care agent, you doctor, and others who might need it. Keep a copy at home in a place where someone can get to it if needed. Review what you have written periodically.

**A. Selection of Primary Agent**

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

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

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

Telephone Numbers: \_\_\_\_\_ + \_\_\_\_\_  
(home and cell)

**B. Selection of Back-up Agents:** (optional; form valid if left blank)

B1. 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: \_\_\_\_\_  
(home and cell)

B2. If my primary agent and back-up 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: \_\_\_\_\_  
(home and cell)

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

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

- a. 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:
- b. Decide who my doctor and other health care providers should be; and
- c. Decide where I should be treated, including whether I should be in a hospital, nursing home, other medical facility, or hospice program.
- d. I also want my agent to:
  - i. Ride with me in an ambulance if I ever need to be rushed to the hospital; and
  - ii. Be able to visit me if I am in a hospital or any health care facility.

THIS ADVANCE DIRECTIVE DOES NOT MAKE MY AGENT  
RESPONSIBLE FOR ANY OF THE COSTS OF MY CARE

- e. This power is subject to the following conditions or limitations: (Optional; form is valid if left blank)

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

**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 this document 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 decisions 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:

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

**Access to My Health Information – Federal Privacy Law (HIPAA) Authorization**

- a. 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.
- b. 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.
- c. 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.

G. **Effectiveness of this Part** (Read both statements carefully. Then, initial **one** only.)

My agent’s power is in effect:

- a. 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.

Initial here if selected \_\_\_\_\_

>>OR<<

- b. 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 the ability **temporarily**, or my attending physician and a consulting doctor agree that I have lost this ability **permanently**.

Initial here if selected \_\_\_\_\_

**SIGNATURE AND WITNESSES**

By signing below as the Declarant, I indicate that I am emotionally and mentally competent to select and determine the authority of my health care agent and that I understand the purpose and effect of this document. I also understand that this document replaces any similar document I may have completed before this date.

\_\_\_\_\_  
(Signature of Declarant)

\_\_\_\_\_  
(Date)

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

\_\_\_\_\_  
(Signature of Witness)

\_\_\_\_\_  
(Date)

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

\_\_\_\_\_  
(Signature of Witness)

\_\_\_\_\_  
(Date)

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

**(NOTE:** Anyone selected as a health care agent may not be a witness. Also, at least one of the witnesses must be someone who will not knowingly inherit anything from the Declarant or otherwise gain a financial benefit from the Declarant’s death. Maryland law does **not** require this document to be notarized.)