DESIGNATION OF PATIENT ADVOCATE
EFFECTIVE UPON EXECUTION
WITH APPROPRIATE **HIPAA** LANGUAGE

Concerning (Name):_____

MY WISHES CONCERNING MY HEALTH CARE:

To my Family, Doctors and All Concerned with my care:

These instructions express my wishes about my health care. I want my family, doctors, and everyone else concerned with my care to act in accord with them.

Appointment of Patient Advocate

I appoint the following person(s) my (co- Patient Advocate(s):

Name: _____

Address: _____

Telephone_:_____

As my co-Patient Advocate/successor Patient Advocate (strike one) I appoint:

Name: _____

Address: _____

Telephone_:_____

If either of my co-Patient Advocates (if co-Patient Advocates are appointed) is unwilling or unable to serve, or is unavailable, the remaining Patient Advocate may serve as sole Patient Advocate.

My Patient Advocate(s) or successor Patient Advocate may only act if I am unable to participate in making decisions regarding my medical treatment.

HIPAA Language:

My agent is appointed to act for me and in my name, place and stead and with the same authority I would have if personally present, for the purpose of signing (i) any

Authorization required by the Final Privacy Regulations issued pursuant to the Health Insurance Accountability and Portability Act in order to obtain access to Protected Health Information (PHI) about me and (ii) any other consent or release that might be required to authorize the release, use or disclosure of confidential health information.

Regardless of whether a determination has been made about whether I am able to participate in medical treatment decision making, I want anyone reading this document to understand that by naming

_____

_____

(if no names are listed above the names on the first page of this appointment is incorporated by references thereto) as my co-Patient Advocates I have identified then as a persons involved with my care within the meaning of 45 CFR 164.510(b)(i) of the HIPAA Final Rules.

I want a Covered Entity to (i) use its professional judgment to infer that I would not object to any disclosure of PHI if I am present in circumstances described in 45 CFR 164.510(b)(2). If I am not present or it is not practical to give me an opportunity to agree or object to the use or disclosure as described in 45 CFR 164.510(b)(3), then I authorize a Covered Entity to use its professional judgment to determine that it is in my best interests to disclose PHI that is directly relevant to the authority of

_____

(if no names are listed above the names on the first page of this appointment is incorporated by references thereto) as my co-Patient Advocates.

Instructions For Care

1. General Instructions

My co-Patient Advocates shall have the authority to make all decisions and to take all actions regarding my care, custody and medical treatment including, but not limited to the following:

a. Have access to, obtain copies of and authorize release of my medical and other personal information.

b. Employ and discharge physicians, nurses, therapists, and any other health care providers, and arrange to pay them reasonable compensation.

c. Consent to, refuse or withdraw for me any medical care; diagnostic, surgical, or therapeutic procedure; or other treatment of any type or nature, including life-sustaining treatments. I understand that life sustaining treatment includes, but is not limited to breathing with the use of a machine and receiving food, water and other liquids through tubes. I also understand that these decisions could or would allow me to die. I have listed below any specific instructions I have related to life-sustaining treatments.

2. Specific Instructions Regarding Life-Sustaining Treatment

I understand that I do not have to choose one of the instructions regarding life sustaining treatment listed below. If I choose one, I will sign below my choice.

If I sign one of the choices listed below, I direct that reasonable measures be taken to keep me comfortable and relieve pain.

Choice 1: I do not want my life to be prolonged by providing or continuing life-sustaining treatment if any of the following medical conditions exist:

I am in an irreversible coma or persistent vegetative state.

I am terminally ill and life-sustaining procedures would serve only to artificially delay my death.

Under any circumstances where my medical condition is such that the burdens of the treatment outweigh the expected benefits. In weighing the burdens and benefits of treatment, I want my Patient Advocate to consider the relief of suffering and the quality of my life as well as the extent of possibly prolonging my life.

I understand that this decision could or would allow me to die.

If this statement reflects your desires, sign here:

_____

Choice 2: I want my life to be prolonged by life-sustaining treatment unless I am in a coma or vegetative state which my doctor reasonably believes to be irreversible. Once my doctor has reasonably concluded that I will remain unconscious for the rest of my life, I do not want life-sustaining treatment to be provided or continued. I understand that this decision could or would allow me to die.

If this statement reflects your desires, sign here:

_____

Choice 3: I want my life to be prolonged to the greatest extent possible consistent with sound medical practice without regard to my condition, the chances I have for recovery, or the cost of my care, and I direct life-sustaining treatment be provided in order to prolong my life.

If this statement reflects your desires, sign here:

_____

3. General Patient Advocate Provisions:

- This document is to be treated as a Durable Power of Attorney for Health Care and shall survive my disability or incapacity.
- If I am unable to participate in making decisions for my care and there is no Patient Advocate or successor Patient Advocate able to act for me, I request that the instructions I have given in this document be followed and that this document be treated as conclusive evidence of my wishes.
- It is also my intent that anyone participating in my medical treatment shall not be liable for following the directions of my Patient Advocate that are consistent with my instructions.
- This document is signed in the State of Michigan. It is my intent that the laws of the State of Michigan govern all questions concerning its validity, the interpretation of its provisions and its enforceability. I also intend that it be applied to the fullest extent possible wherever I may be.
- **Photocopies** of this document can be relied upon as though they were originals.

- I am providing these instructions of my free will. I have not been required to give them in order to receive or have care withheld or withdrawn. I am at least eighteen years old and of sound mind.

_____
Name of Person Appointing Patient Advocates

_____
Signature of Person Appointing Patient Advocates

Dated: This _____ day of _____, 200___

Witnesses:

_____

Dated:

_____

Dated: