DECLARATION RELATING TO USE OF LIFE-SUSTAINING PROCEDURES (Living Will) AND DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS (Medical Power of Attorney)

1. DECLARATION RELATING TO LIFE-SUSTAINING PROCEDURES

If I should have an incurable or irreversible condition that will result either in death within a relatively short period of time or a state of permanent unconsciousness from which, to a reasonable degree of medical certainty, there can be no recovery, it is my desire that my life not be prolonged by the administration of life-sustaining procedures. If I am unable to participate in my health care decisions, I direct my attending physician or attending physician assistant to withhold or withdraw life-sustaining procedures that merely prolong the dying process and are not necessary to my comfort or freedom from pain.

This declaration is subject to any specific instructions or statement of desires I have added in "Additional Provisions" below.

2. POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

I,_____, born_____, designate _____

_____

(Type or Print) Name of Agent, Street Address, City, State, Zip Code and Phone Number.

as my attorney in fact (my agent) and give to my agent the power to make health care decisions for me. This power exists only when I am unable, in the judgment of my attending physician or attending physician assistant, to make those health care decisions. The attorney in fact must act consistently with my desires as stated in this document or otherwise made known.

Except as otherwise specified in this document, this document gives my agent the power, where otherwise consistent with the laws of the State of Iowa, to consent to my physician or attending physician assistant not giving health care or stopping health care which is necessary to keep me alive.

This document gives my agent power to make health care decisions on my behalf, including to consent, to refuse to consent, or to withdraw consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition. This power is subject to any statement of my desires and any limitations included in this document.

I hereby revoke all prior Durable Powers Of Attorney for Health Care Decision.

OPTIONAL: If the person designated as agent above is unable to serve, I designate the following person to serve instead:_____

_____

(Type or Print) Name of Agent, Street Address, City, State, Zip Code and Phone Number.

OPTIONAL: ADDITIONAL PROVISIONS - Insert specific instructions or statement of desires (if any): _____

_____

YES__ NO__ In the event that medical professionals determine that I may be an organ donor, I agree to the use of life-sustaining procedures, including a ventilator, for the sole purpose and time period required to complete the organ donation. Nothing in this paragraph shall be construed to expand or detract from the laws related to anatomical gifts as outlined in the Iowa Code, Chapter 142C. The purpose of this paragraph is to practically and medically make organ donation possible.

Signed on _____.

_____ _____

Your Signature Type or Print Your Name
Address, Street, City State and Zip

IMPORTANT NOTE: THIS DOCUMENT MUST BE SIGNED OR ACKNOWLEDGED BEFORE A NOTARY PUBLIC OR TWO WITNESSES. SEE REVERSE FOR NOTARY OR WITNESS FORMS. IF YOU WANT TO EXECUTE EITHER A LIVING WILL DECLARATION OR A MEDICAL POWER OF ATTORNEY, BUT NOT BOTH, SEPARATE FORMS ARE AVAILABLE FROM THE IOWA STATE BAR ASSOCIATION. IF YOU HAVE QUESTIONS REGARDING THIS FORM OR NEED ASSISTANCE TO COMPLETE IT, YOU SHOULD CONSULT AN ATTORNEY.

WITNESS FORM

We, the undersigned, hereby state that we signed this document in the presence of each other and the Declarant/Principal and we witnessed the signing of the document by the Declarant/Principal or by another person acting on behalf of the Declarant/Principal at the direction of the Declarant/Principal; that neither of us is appointed as attorney in fact by this document; that neither of us are health care providers who are presently treating the Declarant/Principal, or employees of such a health care provider. We further state that we are both at least 18 years of age, and that at least one of us is not related to the Declarant/Principal by blood, marriage or adoption.

_____ _____

Signature of First Witness Signature of Second Witness

_____ _____

Type or Print Name of Witness Type or Print Name of Witness
Street Address, City, State, Zip Code Street Address, City, State, Zip Code

-OR-

STATE OF _____, COUNTY OF _____

This record was acknowledged before me on _____, by _____.

_____

Signature of Notary Public

GENERAL INFORMATION REGARDING THIS DOCUMENT

1. "Health care" means any care, treatment, service, or procedure to maintain, diagnose, or treat an individual's physical or mental condition. "Life-sustaining procedure" means any medical procedure, treatment, or intervention which utilizes mechanical or artificial means to sustain, restore, or supplement a spontaneous vital function, and when applied to a person in a terminal condition, would serve only to prolong the dying process. "Life sustaining procedure" does not include administration of medication or performance of any medical procedure deemed necessary to provide comfort care or to alleviate pain.
2. The terms "health care" and "life-sustaining procedure" include nutrition and hydration (food and water) only when provided parenterally or through intubation (intravenously or by feeding tube). Thus, this document authorizes withholding nutrition or hydration that is provided intravenously or by feeding tube. If this is not what you want, you should set forth your specific instructions in the space provided on page 1.
3. The following individuals shall not be designated as the attorney in fact to make health care decisions under a durable power of attorney for health care:
    a. A health care provider attending the principal on the date of execution.
    b. An employee of such a health care provider unless the individual to be designated is related to the principal by blood, marriage, or adoption within the third degree of consanguinity.
4. The power of attorney for health care decisions or the declaration relating to use of life-sustaining procedures may be revoked at any time and in any manner by which the principal/declarant is able to communicate with the intent to revoke, without regard to mental or physical condition. A revocation is only effective to the attending health care provider upon its communication to the provider by the principal/declarant or by another to whom the principal/declarant has communicated the revocation.
5. It is the responsibility of the principal/declarant to provide the attending health care provider with a copy of this document.
6. A declaration relating to use of life-sustaining procedures will be given effect only when the declarant's condition is determined to be terminal or the declarant is in a state of permanent unconsciousness, and the declarant is not able to make treatment decisions.

SUGGESTIONS AFTER FORM IS PROPERLY SIGNED, WITNESSED OR NOTARIZED

1. Place original in a safe place known and accessible to family members or close friends.
2. Provide a copy to your doctor.
3. Provide a copy(s) to family member(s).
4. Provide a copy to the designated attorney in fact (agent) and to alternate designated attorneys in fact (if any).

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION TO NOMINATED HEALTH CARE ATTORNEY-IN-FACT

Pursuant to the terms of a Durable Power of Attorney, Health Care Decisions, (or Combined Living Will and Medical Power of Attorney) (HCPOA) dated _____, in which the undersigned is the grantor, the power becomes effective in the event of my disability or incapacity.

AUTHORIZATION TO RELEASE INFORMATION

I authorize any physician, health care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy, or other covered health care provider, any insurance company and the Medical Information Bureau, Inc., or 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, to give, disclose, and release to the person or persons designated in this document to act as my agent such of my individually identifiable health information and medical records regarding any past, present or future medical or mental health condition

(including all specially protected health information relating to each of the following conditions specifically authorized by me to be disclosed by marking the box with an "X" or a check mark):

☐ sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), and human immunodeficiency virus (HIV);

☐ behavioral and mental health;

☐ alcohol, drug and other substance abuse; and

☐ genetic-related information);

_____ _____

Signature of Principal Date

relating to my ability to make health care decisions. The purpose of this request is to assist in determining whether the person designated to act as my agent should act as my agent. This authorization expires when I die or when revoked by me by a written revocation signed by me and delivered to the entity from which information is being requested prior to the time information is being requested.

I understand I can revoke this authorization by delivering a written statement of revocation to any entity I have authorized to give, disclose and release information. The revocation is effective only as to those entities to whom the written statement revocation is given and only after the time of delivery. I also understand that I have the right to inspect the disclosed information at any time. My treatment, payment, enrollment or eligibility for benefits with an entity that I have authorized to release information is not conditioned on my signing this authorization. I know that once the information I have authorized to be released is released it is subject to re-disclosure by the recipient and is no longer protected by the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated pursuant thereto, as amended from time to time.

THE AUTHORITY TO ACT AS PERSONAL REPRESENTATIVE

In addition to the other powers granted by the HCPOA, I grant to my agent the power and authority to serve as my personal representative for all purposes of the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, and its regulations (HIPAA) during any time that my agent (hereinafter referred to in subsequent clauses of this paragraph as my "HIPAA personal representative") is exercising authority under this document.

Pursuant to HIPAA, I specifically authorize my HIPAA personal representative to request, receive and review any information regarding my physical or mental health, including without limitation all HIPAA-protected health information, medical and hospital records; to execute on my behalf any authorizations, releases, or other documents that may be required in order to obtain this information and to consent to the disclosure of this information. I further authorize my HIPAA personal representative to execute on my behalf any documents necessary or desirable to implement the health care decisions that my HIPAA personal representative is authorized to make under the HCPOA.

Dated on _____.

_____

, Grantor