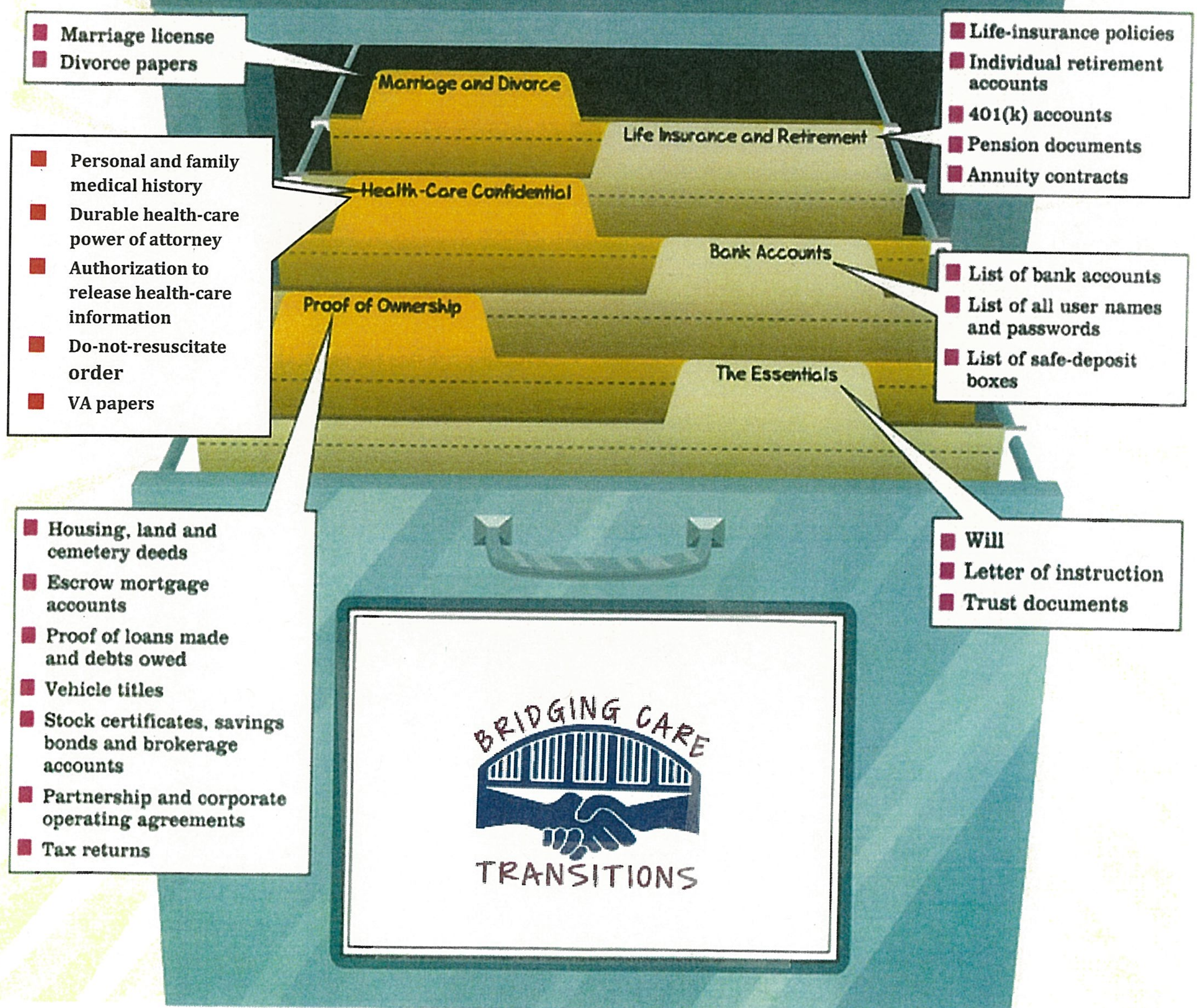
# *"Love Your Loved Ones **Enough** To Let Them Know Your Wishes"*

# The 25 Documents You Need Before You Die

## Design Your Death Dossier Soon—or You Could Be Setting Up Your Heirs for Frustration and Financial Pain



# WALLET CARDS FOR ALABAMA ADVANCE DIRECTIVES

**Cut out and complete the cards below. Put one card in the wallet or purse you carry most often, along with your driver's license or health insurance card. You can keep the second card on your refrigerator, in your motor vehicle glove compartment, a spare wallet or purse, or other easy-to-find place.**

**ATTN: ALABAMA HEALTH CARE PROVIDERS**
I have created the following Advance Directives:
*(Check one or both)*

___ Alabama Living Will
___ Appointment of a Health Care Proxy

Please contact________________________________
(Name)
at ___________________________________________
(Address)
and_____________________ for more information.
(Telephone)

_______________ _______________________
(Date) (Signature)

**ATTN: ALABAMA HEALTH CARE PROVIDERS**
I have created the following Advance Directives:
*(Check one or both)*

___ Alabama Living Will
___ Appointment of a Health Care Proxy

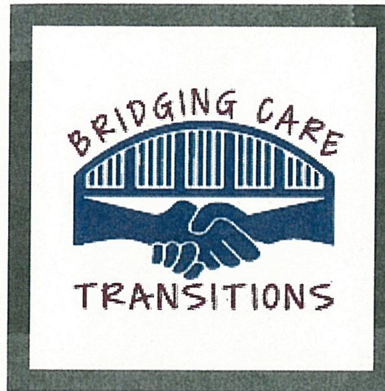
Please contact________________________________
(Name)
at ___________________________________________
(Address)
and_____________________ for more information.
(Telephone)

_______________ _______________________
(Date) (Signature)

© Copyright
Professional Media Resources
PO Box 460380
St. Louis, MO 63146-7380
800-753-4251

INDIVIDUALS MAY OBTAIN ADDITIONAL COPIES OF THIS BOOKLET BY VISITING OUR WEBSITE AT: WWW.ADVDIR.COM

All rights reserved. Parts of this publication may not be reproduced or transmitted in any form or by any means, electronic or mechanical, including photocopying, recording, or any information or storage and retrieval systems, without permission in writing from the publisher. Individuals and patients may make copies of the legal forms for distribution as recommended in this booklet.




# HIPAA Privacy Authorization

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

1. I authorize ______________________________________ (healthcare provider) to use and disclose the protected health information described below to __________________________________________________ (individual seeking the information/proxy).

2. This authorization for release of information covers healthcare from all past, present, and future periods.

3. I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until ________________________ (Date or specific event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my medical treatment, payment, enrollment, or eligibility for benefits will not depend on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

______________________________________________________________

Signature of patient or personal representative

______________________________________________________________

Printed name of patient or personal representative and his or her relationship to patient

Date ________________________________________

______________________________________________________________

Witness

Date________________________________________

## Glossary

**Advance directive** - A general term that describes two kinds of legal documents, living wills and medical powers of attorney. These documents allow a person to give instructions about future medical care should he or she be unable to participate in medical decisions due to serious illness or incapacity. Each state regulates the use of advance directives differently.

**Artificial nutrition and hydration** – Artificial nutrition and hydration supplements or replaces ordinary eating and drinking by giving a chemically balanced mix of nutrients and fluids through a tube placed directly into the stomach, the upper intestine or a vein.

**Brain death** – The irreversible loss of all brain function. Most states legally define death to include brain death.

**Capacity** - In relation to end-of-life decision-making, a patient has medical decision making capacity if he or she has the ability to understand the medical problem and the risks and benefits of the available treatment options. The patient's ability to understand other unrelated concepts is not relevant. The term is frequently used interchangeably with competency but is not the same. Competency is a legal status imposed by the court.

**Cardiopulmonary resuscitation** - Cardiopulmonary resuscitation (CPR) is a group of treatments used when someone's heart and/or breathing stops. CPR is used in an attempt to restart the heart and breathing. It may consist only of mouth-to-mouth breathing or it can include pressing on the chest to mimic the heart's function and cause blood to circulate. Electric shock and drugs also are used frequently to stimulate the heart.

**Do-Not-Resuscitate (DNR) order** - A DNR order is a physician's written order instructing healthcare providers not to attempt cardiopulmonary resuscitation (CPR) in case of cardiac or respiratory arrest. A person with a valid DNR order will not be given CPR under these circumstances. Although the DNR order is written at the request of a person or his or her family, it must be signed by a physician to be valid. A non-hospital.
DNR order is written for individuals who are at home and do not want to receive CPR.

**Emergency Medical Services (EMS):** A group of governmental and private agencies that provide emergency care, usually to persons outside of healthcare facilities; EMS personnel generally include paramedics, first responders and other ambulance crew.

**Healthcare agent:** The person named in an advance directive or as permitted under state law to make healthcare decisions on behalf of a person who is no longer able to make medical decisions.

**Hospice** - Considered to be the model for quality, compassionate care for people facing a life-limiting illness or injury, hospice and palliative care involve a team-oriented approach to expert medical care, pain management, and emotional and spiritual support expressly tailored to the person's needs and wishes. Support is provided to the persons loved ones as well.

**Intubation**- Refers to "endotracheal intubation" the insertion of a tube through the mouth or nose into the trachea (windpipe) to create and maintain an open airway to assist breathing.

**Life-sustaining treatment** - Treatments (medical procedures) that replace or support an essential bodily function (may also be called life support treatments). Life-sustaining treatments include cardiopulmonary resuscitation, mechanical ventilation, artificial nutrition and hydration, dialysis, and other treatments.

**Living will** - A type of advance directive in which an individual documents his or her wishes about medical treatment should he or she be at the end of life and unable to communicate. It may also be called a "directive to physicians", "healthcare declaration," or "medical directive."

**Mechanical ventilation** - Mechanical ventilation is used to support or replace the function of the lungs. A machine called a ventilator (or respirator) forces air into the lungs. The ventilator is attached to a tube inserted in the nose or mouth and down into the windpipe (or trachea).

**Medical power of attorney** - A document that allows an individual to appoint someone else to make decisions about his or her medical care if he or she is unable to communicate. This type of advance directive may also be called a healthcare proxy, durable power of attorney for healthcare or appointment of a healthcare agent. The person appointed may be called a healthcare agent, surrogate, attorney-in-fact or proxy.

**Palliative care** - A comprehensive approach to treating serious illness that focuses on the physical, psychological, spiritual, and existential needs of the patient. Its goal is to achieve the best quality of life available to the patient by relieving suffering, and controlling pain and symptoms.

**Power of attorney** – A legal document allowing one person to act in a legal matter on another's behalf regarding to financial or real estate transactions.

**Respiratory arrest:** The cessation of breathing - an event in which an individual stops breathing. If breathing is not restored, an individual's heart eventually will stop beating, resulting in cardiac arrest.

**Surrogate decision-making** - Surrogate decision-making laws allow an individual or group of individuals (usually family members) to make decisions about medical treatments for a patient who has lost decision-making capacity and did not prepare an advance directive. A majority of states have passed statutes that permit surrogate decision making for patients without advance directives.

**Ventilator** – A ventilator, also known as a respirator, is a machine that pushes air into the lungs through a tube placed in the trachea (breathing tube). Ventilators are usedwhen a person cannot breathe on his or her own or cannot breathe effectively enough to provide adequate oxygen to the cells of the body or rid the body of carbon dioxide.

**Withholding or withdrawing treatment** - Forgoing life-sustaining measures or discontinuing them after they have been used for a certain period of time.

# ADVANCE DIRECTIVE FOR HEALTH CARE PREPARATION KIT

## Instructions for Completing Your Alabama Advance Directive for Health Care

### How do I make my *Alabama Advance Directive for Health Care* legal?

The law requires that you sign your document, or direct another to sign it, in the presence of two witnesses, who must be at least 19 years of age.

Your witnesses **cannot** be:

- your appointed health care proxy,
- related to you by blood, adoption or marriage,
- entitled to any portion of your estate upon your death, either through your will or under the laws of interstate succession,
- directly financially responsible for your medical care, or
- the person who signed your document on your behalf.

These witnesses must also sign the document to show that they personally know you, believe you to be of sound mind, and that they do not fall into any of the categories of people who cannot be witnesses.

*Note: You do not need to notarize your Alabama Advance Directive.*

### Can I add personal instructions to my *Living Will?*

One of the strongest reasons for naming a proxy is to have someone who can respond flexibly as your medical situation changes and deal with situations that you did not foresee. If you add instructions to this document it may help your proxy carries out your wishes, but be careful that you do not unintentionally restrict your proxy's power to act in your best interest. In any event, be sure to talk with your proxy about your future medical care and describe what you consider to be an acceptable "quality of life."

### Whom should I appoint as my proxy?

Your proxy is the person you appoint to make decisions about your medical care if you become unable to make those decisions yourself. Your proxy may be a family member or a close friend whom you trust to make serious decisions. The person you name as your proxy should clearly understand your wishes and be willing to accept the responsibility of making medical decisions for you.

You can appoint a second person as your alternate proxy. The alternate will step in if the first person you name as a proxy is unable, unwilling, or unavailable to act for you.

## Instructions for Completing Your Alabama Advance Directive for Health Care (continued)

### What if I change my mind?

You may revoke your Advance Directive for Health Care at any time by:

- obliterating, burning, tearing or otherwise destroying or defacing the document,
- executing, or directing another person to execute, a signed and dated written revocation (formal statement that you have changed your mind), or
- orally expressing your intent to revoke the Advance Directive for Health Care in the presence of a witness, 19 years of age or older, who must sign and date a written confirmation that you made an oral revocation. An oral revocation becomes effective once the signed and dated confirmation is given to your doctor or health care provider, who will then make it a part of your medical record.

### What other important facts should I know?

The directions of a pregnant patient's Alabama Advance Directive for Health Care authorizing the providing, withdrawal or withholding of life-sustaining treatments and artificially provided nutrition and hydration will not be honored due to restrictions in the state law.

Your proxy, if you appoint one, does not have authority to authorize psychosurgery, sterilization, or abortion—unless it is necessary to save your life—or to have you involuntarily hospitalized or treated for mental illness.

**You Have Filled Out Your Alabama Advance Directive for Health Care, Now What?**

1. Your *Alabama Advance Directive for Health Care* is an important legal document. Keep the original signed document in a secure but accessible place. Do not put the original document in a safe deposit box or any other security box that would keep others from having access to it.

2. Alabama law requires that your proxy accept his or her role in writing. If your proxy is unavailable to sign this document immediately, a copy of the entire form should be mailed to the proxy, who should then return a signed copy of the proxy signature page.

3. Give photocopies of the signed original to your agent and alternate agent, doctor(s), family, close friends, clergy and anyone else who might become involved in your health care. If you enter a nursing home or hospital, have photocopies of your document placed in your medical records.

4. Be sure to talk to your agent(s), doctor(s), clergy, family and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.

5. Alabama does not maintain an Advance Directive Registry, but you may file your advance directive with the office of the probate judge in the county in which you reside. Although no one is required to search for your advance directive, filing your advance directive may help your health care provider and loved ones find a copy of your directive in the event you are unable to provide one.

6. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

7. If you want to make changes to your documents after they have been signed and witnessed, you must complete a new document.

8. Remember, you can always revoke your Alabama document.

9. Be aware that your Alabama document will not be effective in the event of a medical emergency. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate directive that states otherwise. These directives called "prehospital medical care directives" or "do not resuscitate orders" are designed for people whose poor health gives them little chance of benefiting from CPR. These directives instruct ambulance and hospital emergency personnel not to attempt CPR if your heart or breathing should stop. We suggest you speak to your physician for more information. **CaringInfo does not distribute these forms.**

INSTRUCTIONS

# ALABAMA ADVANCE DIRECTIVE FOR HEALTH CARE 

This form may be used in the State of Alabama to make your wishes known about what medical treatment or other care you would or would not want if you become too sick to speak for yourself. You are not required to have an advance directive. If you do have an advance directive, be sure that your doctor, family, and friends know you have one and know where it is located.

## Section 1. LIVING WILL

PRINT YOUR NAME

I, ___________________________, being of sound mind and at least 19 years old, would like to make the following wishes known. I direct that my family, my doctors and health care workers, and all others follow the directions I am writing down. I know that at any time I can change my mind about these directions by tearing up this form and writing a new one. I can also do away with these directions by tearing them up and by telling someone at least 19 years of age of my wishes and asking him or her to write them down.

I understand that these directions will only be used if I am not able to speak for myself.

### IF I BECOME TERMINALLY ILL OR INJURED:

Terminally ill or injured is when my doctor and another doctor decide that I have a condition that cannot be cured and where death will result in the near future without the use of artificial life sustaining procedures.

### Life-Sustaining Treatment:

Life-Sustaining Treatment includes drugs, machines, or medical procedures that would keep me alive but would not cure me. I know that even if I choose not to have life-sustaining treatment, I will still get medicines and treatments that ease my pain and keep me comfortable.

PLACE YOUR INITIALS BY EITHER YES OR NO

Place your initials by either Yes or No:
I want to have life-sustaining treatment if I am terminally ill or injured.
Yes________ No_________

Artificially provided food and hydration (Food and water through a tube or an IV) - I understand that if I am terminally ill or injured I may need to be given food and water through a tube or an IV to keep me alive if I can no longer chew or swallow on my own or with someone helping me.

PLACE YOUR INITIALS BY EITHER YES OR NO

Place your initials by either Yes or No:
I want to have food and water provided through a tube or an IV if I am terminally ill or injured. Yes______ No_______

© 2005 National Hospice and Palliative Care Organization 2016 Revised.

IF I BECOME PERMANENTLY UNCONSCIOUS:

Permanent unconsciousness is when my doctor and another doctor agree that within a reasonable degree of medical certainty I can no longer think, feel anything, knowingly move, or be aware of being alive. They believe this condition will last indefinitely without hope for improvement and have watched me long enough to make that decision. I understand that at least one of these doctors must be qualified to make such a diagnosis.

Life-Sustaining Treatment:

Life-sustaining treatment includes drugs, machines, or other medical procedures that would keep me alive but would not cure me. I know that even if I choose not to have life-sustaining treatment, I will still get medicine and treatments that ease my pain and keep me comfortable.

PLACE YOUR INITIALS BY EITHER YES OR NO

Place your initials by either Yes or No:
I want to have life-sustaining treatment if I am permanently unconscious.
Yes____ No____

Artificially Provided Food and Hydration:

Artificially provided food and hydration (Food and water through a tube or an IV) I understand that if I become permanently unconscious, I may need to be given food and water through a tube or an IV to keep me alive if I can no longer chew or swallow on my own or with someone helping me.

PLACE YOUR INITIALS BY EITHER YES OR NO

Place your initials by either Yes or No:
I want to have food and water provided through a tube or an IV if I am permanently unconscious. Yes______ No_______

© 2005 National Hospice and Palliative Care Organization 2016 Revised.

ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

OTHER DIRECTIONS:

Please list any other things that you want done or not done:

In addition to the directions I have listed on this form, I also direct the following:

____________________________________________________________

IF YOU DO NOT HAVE OTHER DIRECTIONS, PLACE YOUR INITIALS HERE

If you do not have other directions, place your initials here:

__________ No, I do not have other directions.

© 2005 National Hospice and Palliative Care Organization 2016 Revised.

PLACE YOUR INITIALS BY ONLY ONE ANSWER

PRINT THE NAME, RELATIONSHIP AND ADDRESS OF YOUR PROXY

PRINT THE NAME, RELATIONSHIP AND ADDRESS OF YOUR ALTERNATE PROXY

© 2005 National Hospice and Palliative Care Organization 2016 Revised.

## Section 2. HEALTH CARE PROXY

This form can be used in the State of Alabama to name a person you would like to make medical or other decisions for you if you become too sick to speak for yourself. This person is called a health care proxy. You do not have to name a health care proxy. The directions in this form will be followed even if you do not name a health care proxy.

This Section 2 creates a power of attorney that shall become effective upon the disability, incompetence, or incapacity of the principal, and is in substantially the same form as set forth in the Alabama Natural Death Act.

Place your initials by only one answer:
_______ I do not want to name a health care proxy.
(If you check this answer go to section 3.)

_______ I do want the person listed below to be my health care proxy.
I have talked with this person about my wishes.

First choice for proxy:_______________________________________________

Relationship to me:_______________________________________________

Address:_______________________________________________

City:______________________ State:________ Zip:______________

Day-time phone number: _______________________________________________

Night-time phone number:_______________________________________________

If this person is not able, not willing, or not available to be my health care proxy, this is my next choice:

Second choice for proxy: _______________________________________________

Relationship to me:_______________________________________________

Address:_______________________________________________

City:______________________ State:________ Zip:______________

Day-time phone number: _______________________________________________

Night-time phone number:_______________________________________________

INITIAL
YES OR NO

PLACE YOUR
INITIALS BEFORE
ONE OF THE THREE
OPTIONS

Instructions for Proxy

Place your initials by either yes or no:

I want my health care proxy to make decisions about whether to give me food and water through a tube or an IV.
Yes_____ No_____

Place your initials by only one of the following:

_____ I want my health care proxy to follow only the directions as listed on this form.

_____ I want my health care proxy to follow my directions as listed on this form and to make any decisions about things I have not covered in the form.

_____ I want my health care proxy to make the final decision, even though it could mean doing something different from what I have listed on this form.

Section 3.

The things listed on this form are what I want.

I understand the following:

If my doctor or hospital does not want to follow the directions I have listed, they must see that I get to a doctor or hospital that will follow my directions.

If I am pregnant, or if I become pregnant, the choices I have made on this form will not be followed until after the birth of the baby.

LIST THE PEOPLE
YOU WOULD WANT
YOUR DOCTOR TO
TALK WITH

If the time comes for me to stop receiving life-sustaining treatment or food and water through a tube or an IV, I direct that my doctor talk about the good and bad points of doing this, along with my wishes, with my health care proxy, if I have one, and with the following people:

______________________________________________

______________________________________________

______________________________________________

© 2005 National
Hospice and
Palliative Care
Organization
2016 Revised.

ORGAN DONATION (OPTIONAL)

Section 4.

ORGAN DONATION (OPTIONAL)

In the space below you may make a gift yourself or state that you do not want to make a gift. **The donation elections you make below survive your death.**

Initial the line next to the statement below that best reflects your wishes. You do not have to initial any of the statements. **If you do not initial any of the statements, your agent and your family will have the authority to make a gift of all or part of your body under Alabama law.**

CHECK THE OPTION THAT REFLECTS YOUR WISHES

_____ I do not want to make an organ or tissue donation and I do not want my agent or family to do so.
_____ I have already signed a written agreement or donor card regarding organ and tissue donation with the following individual or institution:
Name of individual / institution: ______________________________

_____ Pursuant to Alabama law, I hereby give, effective on my death: (Select one)

_____ Any needed organ or parts.
_____ The following part or organs listed below:

CHECK THE OPTION THAT REFLECTS YOUR WISHES. ADD PERSONAL INSTRUCTIONS, IF ANY

For the following purpose: (Select one)
_____ Any legally authorized purpose.
_____ Transplant or therapeutic purposes only.

© 2005 National Hospice and Palliative Care Organization 2016 Revised.

PRINT YOUR NAME, THE MONTH, DAY AND YEAR OF YOUR BIRTH

SIGN AND DATE YOUR DOCUMENT

WITNESSING PROCEDURE

WITNESSES MUST SIGN THEIR NAMES

WITNESS #1

WITNESS #2

© 2005 National Hospice and Palliative Care Organization 2016 Revised.

## Section 5. Execution

My signature

Your Name_______________________________________

The Month, Day, and Year of your birth: ______________________

Your signature:__________________________________

Date signed:____________________________________

Witnesses (need two witnesses to sign)

I am witnessing this form because I believe this person to be of sound mind. I did not sign the person's signature and I am not the health care proxy. I am not related to the person by blood, adoption, or marriage and not entitled to any part of his or her estate. I am at least 19 years of age and am not directly responsible for paying for his or her medical care.

Name of first witness:______________________________

Signature:____________________________ Date:__________

Name of second witness:____________________________

Signature:____________________________ Date:__________

THE PROXY AND ANY ALTERNATE PROXY MUST PRINT THEIR NAMES AND SIGN AND DATE THE DOCUMENT

IF EITHER PROXY IS UNAVAILABLE TO SIGN THIS DOCUMENT IMMEDIATELY, A COPY OF THE ENTIRE FORM SHOULD BE MAILED TO THE PROXY, WHO SHOULD THEN RETURN A SIGNED COPY OF THE PROXY SIGNATURE PAGE.

Section 6. Signature of Proxy

I, ______________________________, am willing to serve as the health care

proxy for ______________________________.

Signature: ______________________________
Date:____________________

Signature of second choice for proxy:

I, ______________________________, am willing to serve as the health care

proxy for ______________________________ if the first choice cannot serve.

Signature: ______________________________
Date:____________________

© 2005 National Hospice and Palliative Care Organization 2016 Revised.

*Courtesy of CaringInfo*
*1731 King St., Suite 100, Alexandria, VA 22314*
*www.caringinfo.org, 800/658-8898*