

Advance Directive and Durable Power of Attorney
Declaration Relating to Life-Sustaining
Procedures and Durable Power of Attorney
for Health Care Decisions

State of Iowa

The Rest of Your Life recommends that you review completed documents with an attorney, especially if there are mitigating circumstances surrounding your Advance Directive or Durable Power of Attorney.

Advance Directives Electronic Forms

The ROYL is a leader in offering electronic Advance Directive documents for digital signatures. Electronic Advance Directive Forms are secure and accessible anytime from any device that allows for Internet access.

Why do an Advance Directive?

Anyone 18 years of age or older should have an Advance Directive. This document allows for the care you have designated to be respected and followed through in the event you cannot speak for yourself. It allows for you to name someone to speak on your behalf, but most importantly it removes the stress, anxiety and guilt from decisions that your loved ones would otherwise have to make on your behalf.

An Advance Directive is not just for aging people. The cases of Teri Shivo and Karen Ann Quinlan serve as examples of how any adult, regardless of age, can benefit from having one. Both young adults, Shivo and Quinlan were kept alive by machines for years because they did not tell or write down what they wanted in the event of a tragic accident. The court battles that ensued took not only an emotional toll, but required government involvement because of disagreements between spouses and family members.

Description:

An Advance Directive, sometimes referred to as a Living Will or an Advance Health Care Directive, allows you to make your wishes known if you are unable to speak for yourself. An Advance Directive provides you and your loved ones with peace of mind that your care is compatible with your wishes. This is truly a gift to those you love as it helps them clearly know what to do in this stressful situation.

Advance Directive requirements vary from state to state. You can download the appropriate state form here at no cost prior to completing the form online so that you have the required information prepared in advance.

Security:

Your documents are processed using DocuSign, the leader in global electronic signature and document security.

When you complete your Advance Directive with The ROYL, you can download it as a PDF file to your computer's hard drive. DocuSign will email a final copy to the designees in your Advance Directive. We recommend you print a hard copy and send it via email or mail to others you want to have copies.

Contact us if you have questions in preparing the forms selected.

NOTICE: You must have the required information available prior to initiating the document (designees, contact information, wishes for care).

NOTARY PUBLIC FORM

STATE OF _____, COUNTY OF _____ ss:

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

_____, Notary Public

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

Street Address

City State Zip Code

City State Zip Code

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 the intent to revoke, without regard to mental or physical condition. A revocation is only effective as 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; and
- alcohol, drug and other substance abuse)

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 this _____ day of _____, _____

EXAMPLE

Grantor



A letter to my loved ones...

Dear Loved Ones,

*I want the best quality of life possible during my last days.
Therefore, I hereby request as follows...*

(a) I ask that medical treatment to alleviate pain, to provide comfort, and to mitigate suffering be provided so that I may be as free of pain and suffering as possible. Please consult with my doctor in this regard.

(b) If my temperature is above normal, I want a cool moist cloth put on my head.

(c) I want my mouth and lips kept moist.

(d) I need to be kept fresh and clean at all times. I wish to have warm baths often or warm showers, if I am stable enough for a shower.

(e) I desire to be massaged with or without warm oils as often as you think will help maintain my skin integrity and provide for my comfort.

(f) I want my personal care such as nail clipping, hair combing, teeth brushing and shaving as long as they do not cause me pain.

I hope my family and friends would consider that...

(a) I enjoy your company and want you with me when possible. I desire that one of you stay with me when it seems that my death may be imminent.

(b) Please continue to talk to me about daily happenings and events, even if you think I don't understand, because I might be able to understand.

(c) Please don't be afraid to hold my hand or hug me.

(d) Please tell the members of my church or synagogue I am sick and ask them to pray for me and visit me.

(e) Please maintain a cheerful atmosphere around me.

(f) Please place pictures of my loved ones in my room, near my bed, or near the place I sit during the day.

(g) My clothes and bed linens are to be kept clean, and they are to be changed as soon as possible, if they have been soiled.

(h) If at all possible, allow me to die in my home.

(i) Please arrange for me to watch television or listen to my favorite sports events.

(j) Let me enjoy the outdoors as often as possible by letting me spend time in my yard, garden and other appropriate outdoor places, even if it causes slight discomfort to either you or me.

(k) I want to have my favorite types of music played when possible.

(l) I want to have religious readings read to me when I am near death.

(m) I want to have my favorite poems read to me from time to time.

I want you to know the following about my thoughts and concerns, if I am disabled and cannot convey these thoughts to you verbally...

- (1) I want you to know that I love you.
- (2) I would like to be forgiven for the times I have hurt you.
- (3) I forgive you for what you may have done to me in my life.
- (4) I want you to know that I do not fear death itself.
- (5) I want all of my family members to recommit their love for one another.
- (6) Please remember me the way I was before I had a terminal illness.
- (7) Please help me maintain meaning to my life during this process of dying by realizing that this is an opportunity for personal growth for all.
- (8) Don't be afraid to seek counseling, if you have trouble with my death.

If friends want to know how I want to be remembered, tell them the following...

The following person(s) know my funeral plans...

At any memorial service for me, I want to include the following music, songs, readings or other plans for such a service...

I also have the following requests...

In Process

These are requests of my family members, loved ones, and friends, and are not to be considered legal directives to my attorney-in-fact for health care, if any.

(If you wish to change your answer, you may do so by drawing an "X" through the answer you do not want, and circling the answer you prefer.)

Dated this ____ day of _____, 20 ____.

Signature _____

Print Name _____

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Additional Page:

In Process