Clear Form

Minnesota
Health Care Directive

Purpose of form

Part I. Allows you to appoint another person (called an agent) to make health care decisions if a doctor decides you are unable to do so.
Part II. Allows you to give written instructions about what you want.
Part III. Requires you and others to sign and date to make this legal.

My personal information

My name: _____
Address: _____
_____
Home phone: ( ) _____
Work phone: ( ) _____
Date of birth: _____
Social security #: _____

- I revoke all living wills, Durable Powers of Attorney for Health Care, or other written advance health care directives I have signed in the past.

PART 1: Naming An Agent

Agent duties

My health care agent can:
- Make health care decisions for me if I am unable to make and communicate decisions for myself.
- Make decisions based on any instructions in Part II of this document or in other documents.
- Make decisions based on what he or she knows about my wishes.
- Act in my best interests if instructions are not available.

Agent roles

- When naming my health care agent, I must choose one of the following. *Initial the line in front of the statement you WANT.*

Act alone

_____ I appoint one person to serve as my primary health care agent to make decisions for me if I am unable to make or communicate these decisions for myself. My primary agent may act alone. If my primary agent is not able, willing, or available, each alternate agent I name may act alone, in the order listed.

Act together

_____ I appoint two or more persons to act together as my health care agent. My primary agent and alternate agents must act together and be in agreement when making decisions. If they are not all readily available, or if they disagree, a majority of the agents who are readily available may make decisions for me.

My primary health care agent

I appoint:
Agent's name: _____
Address: _____
_____
Home phone: ( ) _____
Work phone: ( ) _____

My first alternate health care agent

Agent's name: _____
Address: _____
_____
Home phone: ( ) _____
Work phone: ( ) _____

My second alternate health care agent

Agent's name: _____
Address: _____
_____
Home phone: ( ) _____
Work phone: ( ) _____

(If needed) Reasons for naming health care provider

I have named as my agent a health care provider, or employee of a health care provider, who is currently or might be providing direct care to me when decisions are needed. That person is not related to me by blood, marriage, registered domestic partnership, or adoption. My reasons for wanting to appoint that person as my agent are: _____
_____
_____
_____

Powers of my agent

If I am unable to decide or speak for myself, my agent has the power to:

- Consent to, refuse, or withdraw any health care, treatment, service, or procedure
- Stop or not start health care which is keeping or might keep me alive
- Choose my health care providers
- Choose where I live when I need health care and what personal security measures are needed to keep me safe.
- Obtain copies of my medical records and allow others to see them.

Additional powers of my agent

If I WANT my agent to have any of the following powers, I must initial the line in front of the statement.

I also authorize my agent to:

_____ Make health care decisions for me even if I am able to decide or speak for myself.

_____ Carry out my wishes regarding a funeral, burial, or what will happen to my body when I die.

_____ Make decisions about mental health treatment including electroconvulsive therapy and antipsychotic medication, including neuroleptics.

_____ In the event I am pregnant, determine whether to attempt to continue my pregnancy to delivery based upon my agent's understanding of my values, preferences, or instructions.

_____ Continue as my health care agent even if a dissolution, annulment, or termination of our marriage or domestic partnership is in process or has been completed.

Limiting the powers of my agent

I wish to limit the powers of my health care agent in the following way(s): _____
_____

PART II: Health Care Instructions

- I give the following instructions about my health care (my values and beliefs, what I do and do not want, views about medical treatments or situations) _____
  _____
  _____
  _____
  _____
  _____
  _____
  _____
  _____

- I am attaching additional instructions concerning my health care values and preferences. *Initial one line:* _____ Yes _____ No

- I authorize donation of organs, tissue, or other body parts after my death. *Initial one line:* _____ Yes _____ No

PART III: Making This Document Legal

My signature/ mark and date

I agree with everything in this document and have made this document willingly:

My signature: _____

Date: _____
(day / month / year)

Notary Public OR Witnesses

Notary Public

NOTE: Must not be named as agent or alternate agent.

STATE OF MINNESOTA

County of _____

This document was signed or acknowledged before me this _____ (day)

of _____ (month), _____ (year) by the above named principal.

_____
Signature of Notary Public

Two Witnesses

NOTE: Only one witness can be a direct care provider or employee of a provider on the day this is signed.

This document was signed or acknowledged in my presence. I am not an agent or alternate agent in this document.

Witness Signature: _____

Address: _____

_____

Date: _____
(month / day / year)

Witness Signature: _____

Address: _____

_____

Date: _____
(month / day / year)