

1 Testator, *2* Health Care Proxy, *3* First Alternate Health Care Proxy; *4* First Alternate DOB (00/00/0000)

**ADVANCE DIRECTIVE FOR HEALTH CARE
FOR *I***

If I am incapable of making an informed decision regarding my health care, I direct my health care providers to follow my instructions below. I expressly revoke any and all previous Advance Directives for Health Care which I previously executed.

I. LIVING WILL

If my attending physician and another physician determine that I am no longer able to make decisions regarding my medical treatment, I direct my attending physician and other health care providers, pursuant to the Oklahoma Advance Directive Act, to follow my instructions as set forth below:

(1) If I have a terminal condition, that is, an incurable and irreversible condition that even with the administration of life-sustaining treatment will, in the opinion of the attending physician and another physician, result in death within six (6) months:

(Initial only one option)

 I direct that my life not be extended by life-sustaining treatment, except that if I am
(Yes) unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

 I direct that my life not be extended by life-sustaining treatment, including artificially
(Yes) administered nutrition and hydration.

 I direct that I be given life-sustaining treatment and, if I am unable to take food and water
(Yes) by mouth, I wish to receive artificially administered nutrition and hydration.

 See my more specific instructions in paragraph (4) below. (Initial if applicable)

(2) If I am persistently unconscious, that is, I have an irreversible condition, as determined by the attending physician and another physician, in which thought and awareness of self and environment are absent:

(Initial only one option)

 I direct that my life not be extended by life-sustaining treatment, except that if I am
(Yes) unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

____ I direct that my life not be extended by life-sustaining treatment, including artificially
(Yes) administered nutrition and hydration.

____ I direct that I be given life-sustaining treatment and, if I am unable to take food and water
(Yes) by mouth, I wish to receive artificially administered nutrition and hydration.

See my more specific instructions in paragraph (4) below. (Initial if applicable)

(3) If I have an end-stage condition, that is, a condition caused by injury, disease, or illness, which results in severe and permanent deterioration indicated by incompetency and complete physical dependency for which treatment of the irreversible condition would be medically ineffective:

(Initial only one option)

____ I direct that my life not be extended by life-sustaining treatment, except that if I am
(Yes) unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

____ I direct that my life not be extended by life-sustaining treatment, including artificially
(Yes) administered nutrition and hydration.

____ I direct that I be given life-sustaining treatment and, if I am unable to take food and water
(Yes) by mouth, I wish to receive artificially administered nutrition and hydration.

See my more specific instructions in paragraph (4) below. (Initial if applicable)

(4) OTHER. Here you may:

(a) describe other conditions in which you would want life-sustaining treatment or artificially administered nutrition and hydration provided, withheld, or withdrawn,

(b) give more specific instructions about your wishes concerning life-sustaining treatment or artificially administered nutrition and hydration if you have a terminal condition, are persistently unconscious, or have an end-stage condition, or

(c) do both of these:

____ I direct that I be given life-sustaining treatment and, if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration to give my Durable Power of Attorney time to make an informed decision after consulting with two (2) or more physicians regarding their professional recommendation based on the known facts.

_____ (Initial)

(5) PRIVACY RELEASE. I direct that with regard to the use and disclosure of my individually identifiable health information or other medical records, my Health Care Proxies be treated as I would with the power to grant authority for disclosure; This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (a/k/a HIPAA), 42 USC 1320d and 45 CFR 160-164. I authorize: any physician, 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 my agent, without restriction, all of my individually identifiable health information and medical records regarding any past, present or future medical or mental health condition, including all information relating to the diagnosis and treatment of HIV/AIDS, sexually transmitted diseases, mental illness, and drug or alcohol abuse. The authority given my agent shall supersede any prior agreement that I may have made with my health care providers to restrict access to or disclosure of my individually identifiable health information. The authority given my agent has no expiration date and shall expire only in the event that I revoke the authority in writing and deliver it to my health care provider.)

II. MY APPOINTMENT OF MY HEALTH CARE PROXY

If my attending physician and another physician determine that I am no longer able to make decisions regarding my medical treatment, I direct my attending physician and other health care providers pursuant to the Oklahoma Advance Directive Act to follow the instructions of my wife, *2*, whom I appoint as my health care proxy. If my health care proxy is unable or unwilling to serve, I appoint *3* (DOB: *4*), as my alternate health care proxy with the same authority. My health care proxy is authorized to make whatever medical treatment decisions I could make if I were able, except that decisions regarding life-sustaining treatment and artificially administered nutrition and hydration can be made by my health care proxy or alternate health care proxy only as I have indicated in the foregoing sections.

If I fail to designate a health care proxy in this section, I am deliberately declining to designate a health care proxy.

III. ANATOMICAL GIFTS

Pursuant to the provisions of the Uniform Anatomical Gift Act, I direct that at the time of my death my entire body or designated body organs or body parts be donated for purposes of:

(Initial all that apply)

_____ transplantation therapy
(Yes)

_____ advancement of medical science, research, or education
(Yes)

_____ advancement of dental science, research, or education
(Yes)

Death means either irreversible cessation of circulatory and respiratory functions or irreversible cessation of all functions of the entire brain, including the brain stem. If I initial the "yes" line below, I

specifically donate:

_____ My entire body
(Yes)

or

_____ The following body organs or parts:
(Yes)

- | | | | | | |
|--------------------------|--|--------------------------|--------------|--------------------------|--------------|
| <input type="checkbox"/> | lungs | <input type="checkbox"/> | skin | <input type="checkbox"/> | liver |
| <input type="checkbox"/> | pancreas | <input type="checkbox"/> | blood/fluids | <input type="checkbox"/> | heart |
| <input type="checkbox"/> | kidneys | <input type="checkbox"/> | arteries | <input type="checkbox"/> | brain |
| <input type="checkbox"/> | eyes/cornea/lens | <input type="checkbox"/> | tissue | <input type="checkbox"/> | bones/marrow |
| <input type="checkbox"/> | any body parts deemed of use by medical authorities. | | | | |

IV. GENERAL PROVISIONS

- a. I understand that I must be eighteen (18) years of age or older to execute this form.
- b. I understand that my witnesses must be eighteen (18) years of age or older and shall not be related to me and shall not inherit from me.
- c. I understand that if I have been diagnosed as pregnant and that diagnosis is known to my attending physician, I will be provided with life-sustaining treatment and artificially administered hydration and nutrition unless I have, in my own words, specifically authorized that during a course of pregnancy, life-sustaining treatment and/or artificially administered hydration and/or nutrition shall be withheld or withdrawn.
- d. In the absence of my ability to give directions regarding the use of life-sustaining procedures, it is my intention that this advance directive shall be honored by my family and physicians as the final expression of my legal right to choose or refuse medical or surgical treatment including, but not limited to, the administration of life-sustaining procedures, and I accept the consequences of such choice or refusal.
- e. This advance directive shall be in effect until it is revoked.
- f. I understand that I may revoke this advance directive at any time.
- g. I understand and agree that if I have any prior directives, and if I sign this advance directive, my prior directives are revoked.
- h. I understand the full importance of this advance directive and I am emotionally and mentally competent to make this advance directive.

i. I understand that my physician(s) shall make all decisions based upon his or her best judgment applying with ordinary care and diligence the knowledge and skill that is possessed and used by members of the physician's profession in good standing engaged in the same field of practice at that time, measured by national standards.

Signed this _____ day of _____, 2011.

(Signature) *1*

(Street Address)

(City, County, State and ZIP)

(Date of Birth)

This advance directive was signed in my presence.

Witness Residing at _____

Witness Residing at _____
