

# Organ Donation:

After my death, if any of my organs or tissues would be of value as transplants to help others, I do \_\_\_\_\_ / do not \_\_\_\_\_ instruct my next of kin to authorize such donation.

# Other Comments / Instructions:

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## APPOINTMENT OF A HEALTH CARE SURROGATE:

If you are unable to make your own medical decisions the person you appoint as your Health Care Surrogate shall have the authority to:

- (a) Act for you to make health care decisions which he/she believes you would have made under the circumstances if you were able;
- (b) Consult with appropriate health care providers to provide informed consent in your best interest and give consent in writing on the appropriate forms;
- (c) Have access to your clinical records and authority to release information and clinical records to appropriate persons to provide continuity of care;
- (d) Apply for public benefits (such as Medicare and Medicaid) for you and have access to information about your income and assets as needed to make the application; and
- (e) Authorize the transfer and/or admission of you to or from a health care facility.

I \_\_\_\_\_ hereby execute this Advance Directive - Living Will and  
*(Print Name)*

appoint \_\_\_\_\_ as my Health care Surrogate and authorize him/her  
*(Print Name of surrogate)*

to make all decisions for me which he/she believes I would have made.

In the event said person is unable or unwilling to act in such capacity, I appoint as my alternate Health Care

Surrogate: \_\_\_\_\_  
*(Print Name of alternate surrogate)*

I understand the full importance of this declaration, and I am emotionally and mentally competent to make this declaration.

\_\_\_\_\_  
*(Declarant's Signature) (Date) (Date of Birth and Social Security No)*

The declarant is known to me, and I believe him or her to be of sound mind.

\_\_\_\_\_  
*(Witness - any adult) (Date)*

\_\_\_\_\_  
*(Witness - cannot be spouse, blood relative, heir, or person responsible for health care costs.) (Date)*

Surrogate's acceptance signature can be at any time prior to acting as surrogate.

\_\_\_\_\_  
*(Surrogate's Signature) (print name) (Date)*

Patient Label