Gilchrist
11311 McCormick Road, Suite 350
Hunt Valley, MD 21031

Patient Name:____

Date of Birth:______________________

SELECTION OF HEALTH CARE AGENT UNDER AN ADVANCED DIRECTIVE FAQS

Whom should I appoint as my agent?

Your health care agent is the person you appoint, through a written document called an advance directive, to make decisions about your medical care if you become unable to make those decisions yourself. Your agent may be a family member or a close friend whom you trust to make serious decisions. The person you name as your health care agent should clearly understand your wishes and be willing to accept the responsibility of making medical decisions for you. (A health care agent may also be called an "**health care** power of attorney" or "proxy.")

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

Who cannot be your agent:

- An owner, operator or employee of your treating health care facility
- The spouse, parent, child, or sibling of any of the above health care facility affiliated individuals
- The exception to the two above prohibitions is if such person is your guardian, spouse, domestic partner, adult child, parent, sibling, or other close relative or close friend.

You Have Filled Out Your Selection of Health Care Agent/Advance Directive, Now What?

1. 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 healthcare. If you enter a nursing home or hospital, have photocopies of your document placed in your medical records.

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

3. If you want to write your treatment preferences and make your wishes known about future life-sustaining treatment issues, complete a MOLST (Medical Orders for Life-Sustaining Treatment) form, living will, or 5 Wishes document.

If you want to make changes to your Selection of Health Care Agent/Advance Directive after it has been signed and witnessed, you must complete a new document.

Patient Name:____

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MARYLAND ADVANCED DIRECTIVE
SELECTION OF HEALTH CARE AGENT

A. Selection of Primary Agent

I select the following individual as my agent to make health care decisions for me:

Name:____

Relationship to Declarant: ____

Address:____

Telephone Numbers: ____
(please circle: home /cell)

B. Selection of Back-up Agents
(Optional; form valid if left blank)

1. If my primary agent cannot be contacted in time or for any reason is unavailable or unable or unwilling to act as my agent, then I select the following person to act in this capacity:

Name:____

Relationship to Declarant: ____

Address: ____

Telephone Numbers: ____
(please circle: home /cell)

2. If my primary agent and my first back-up agent cannot be contacted in time or for any reason are unavailable or unable or unwilling to act as my agent, then I select the following person to act in this capacity:

Name:____

Relationship to Declarant: ____

Address: ____

Telephone Numbers: ____
(please circle: home /cell)

C. Powers and Rights of Health Care Agent

I want my agent to have full power to make health care decisions for me, including the power to:

1. Consent or not to medical procedures and treatments which my providers offer, including things that are intended to keep me alive, like ventilators and feeding tubes;

2. Decide who my doctor and other health care providers should be; and

3. Decide where I should be treated, including whether I should be in a hospital, nursing home, other medical care facility, or hospice program.

4. I also want my agent to:
   a. Ride with me in an ambulance if ever I need to be rushed to the hospital; and
   b. Be able to visit me if I am in a hospital or any other health care facility.

This power is subject to the following conditions or limitations:
(Optional; form valid if left blank)

____

____

____

D. Access to my Health Information - Federal Privacy Law (HIPAA) Authorization

1. Even if my Agent's power to act is not in effect, I authorize my healthcare team to discuss my care with my Agent.

2. Once my Agent has full power under this document, they can receive copies of any and all of my medical records.

3. For all purposes related to this document, my Agent is my personal representative under HIPAA and may sign any release forms or other HIPAA-related materials.

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E. Effectiveness of this Part

(Read both of these statements carefully. **Then initial <u>ONE</u> only**.)

My agent's power is in effect:

✎_____Whenever I am not able to make informed decisions about my health care, either because the doctor in charge of my care (attending physician) decides that I have lost this ability temporarily, or my attending physician and a consulting doctor agree that I have lost this ability **permanently.**

<<OR>>

✎_____Immediately after I sign this document, subject to my right to make any decision about my health care if I want and am able to.

F. Signature and Witnesses

By signing below as the Declarant, I____________________________________indicate that I am emotionally and mentally competent to make this advance directive and that I understand its purpose and effect. I also understand that this document replaces any similar advance directive I may have completed before this date.

____ _____________________________
(Signature of Declarant) (Date)

The Declarant signed or acknowledged signing this document in my presence and, based upon personal observation, appears to be emotionally and mentally competent to make this advance directive. **

____ _____________________________
(Signature of Witness 1) (Date)

____
Telephone Number(s) Indicate Home/Cell/Work

____ _____________________________
(Signature of Witness 2) (Date)

____
Telephone Number(s) Indicate Home/Cell/Work

**** Witnesses may not be designated health agent. At least one of witnesses must be someone who will not knowingly inherit anything from the Declarant or otherwise knowingly gain a financial benefit from the Declarant's death.**

THIS ADVANCE DIRECTIVE DOES NOT MAKE MY AGENT RESPONSIBLE FOR ANY OF THE COSTS OF MY CARE.

Form Derived from MD Attorney General's "Maryland Advance Directive: Planning for Future Health Care Decisions"