

**ADVANCE HEALTH CARE DIRECTIVE**  
**Including Power of Attorney for Health Care Decisions**  
**California Probate Code Section 4600-4805**

**1. APPOINTMENT OF HEALTH CARE AGENT**

I, \_\_\_\_\_, hereby appoint as my agent to make health care  
*(Print your full name and date of birth)*  
decisions for me:

Name \_\_\_\_\_  
*(agent's name)*

Address \_\_\_\_\_  
*(street address, city, state, zip code)*

Home Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_

Cell Phone ( ) \_\_\_\_\_ Fax ( ) \_\_\_\_\_ email \_\_\_\_\_

**FIRST ALTERNATE AGENT:**

Name \_\_\_\_\_  
*(agent's name)*

Address \_\_\_\_\_  
*(street address, city, state, zip code)*

Home Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_

Cell Phone ( ) \_\_\_\_\_ Fax ( ) \_\_\_\_\_ email \_\_\_\_\_

**SECOND ALTERNATE AGENT:**

Name \_\_\_\_\_  
*(agent's name)*

Address \_\_\_\_\_  
*(street address, city, state, zip code)*

Home Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_

Cell Phone ( ) \_\_\_\_\_ Fax ( ) \_\_\_\_\_ email \_\_\_\_\_

**2. AUTHORITY OF AGENT**

If my primary physician finds that I cannot make my own health care decisions, I grant my agent full power and authority to make those decisions for me, subject to any health care instructions set forth below. My agent will have the right to:

- A. Consent, refuse consent, or withdraw consent to any medical care or services, such as tests, drugs, surgery, or consultations for any physical or mental condition. This includes the provision, withholding or withdrawal of artificial nutrition and hydration (feeding by tube or vein) and all other forms of health care, including cardiopulmonary resuscitation (CPR).
- B. Choose or reject my physician, other health care professionals or health care facilities.
- C. Receive and consent to the release of medical information.
- D. Donate organs or tissues, authorize an autopsy and dispose of my body, unless I have said something different in a contract with a funeral home, in my will, or by some other written method.

I understand that, by law, my agent may not consent to committing me to or placing me in a mental health treatment facility, or to convulsive treatment, psychosurgery, sterilization or abortion.

I want my agent's authority to make health care decisions for me to start now, **even though I am still able to make them for myself**. I understand and authorize this statement as proved by my

signature\_\_\_\_\_

### **3. PRIOR DIRECTIVES REVOKED**

I revoke any prior Power of Attorney for Health Care or Natural Death Act Declaration.

### **4. COPIES**

My agent and others may use copies of this document as though they were originals.



**6. ORGAN AND TISSUE DONATION**

I wish to be an organ donor. I understand and authorize this statement as proved by my

signature \_\_\_\_\_

*If you **do not** wish to be an organ donor, please check this box:*

Other or additional statements of organ and tissue donation desires and limitations.

**I**, \_\_\_\_\_, make this anatomical gift to take effect upon my death:

**I give**

- my body
- any needed organ (e.g., kidneys, liver, heart, lungs, pancreas, spleen), tissue (corneas, heart valves, skin, bone) or parts
- only the following organs, tissues, or parts: \_\_\_\_\_

\_\_\_\_\_

**to**

- the regional organ procurement agency or eye or tissue bank for transplantation or other therapy
- the following university, hospital, storage bank, or other medical institution:

\_\_\_\_\_

\_\_\_\_\_

**for**

- transplantation or treatment of any person who can medically benefit
- medical education
- medical research
- any purpose authorized by law

I understand and authorize this statement as proved by my

signature \_\_\_\_\_

**7. DATE AND SIGNATURE OF PRINCIPAL**

I sign my name to and acknowledge this Advance Heath Care Directive:

\_\_\_\_\_

(signature of principal) (date of birth) (date of signing)

**8. CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC.**

**ACKNOWLEDGMENT BY NOTARY PUBLIC**

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

STATE OF CALIFORNIA )  
 ) ss.  
COUNTY OF \_\_\_\_\_ )

On \_\_\_\_\_, before me, \_\_\_\_\_, Notary Public, personally appeared \_\_\_\_\_, who proved to me on the basis of satisfactory evidence to be the persons whose names are subscribed to the within instrument and acknowledged to me that they executed the same in their authorized capacities, and that by their signatures on the instrument the persons, or the entity upon behalf of which the persons acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

\_\_\_\_\_  
Notary Public [Seal]