Advance Directive

Selection of Health Care Agent

This form lets you answer this question: If you cannot (or do not want to) make your own health care decisions, who do you want to make them for you? The person you pick is called your health care agent.

Who can I appoint as my agent?

You can appoint any competent adult who is 18 years or older to be your agent. However, if that person is also an employee, owner or operator of the healthcare facility where you are being treated, they cannot be your agent unless he or she also qualifies as your surrogate – e.g. spouse, child, parent, brother, sister, etc.

Make sure you talk to your health care agent (and any back-up agents) about this important role.

MedStar Montgomery
Medical Center

Advance Directive –
Selection of Health Care Agent

By: ______________________ (Print Name)   Date of Birth: ______________ (Month/Day/Year)

A. Selection of Primary Agent

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

Name: ______________________

Address: ______________________

____

Telephone Numbers: ______________________

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: ______________________

Address: ______________________

____

Telephone Numbers: ______________________

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: ______________________

Address: ______________________

____

Telephone Numbers: ______________________

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:

- Consent or not to medical procedures and treatments which my doctors offer, including things that are intended to keep me alive, like ventilators and feeding tubes;
- Decide who my doctor and other health care providers should be; and
- Decide where I should be treated, including whether I should be in a hospital, nursing home, other medical care facility, or hospice program.
- 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

- If, prior to the time the person selected as my agent has power to act under this document, my doctor wants to discuss with that person my capacity to make my own health care decisions, I authorize my doctor to disclose protected health information which relates to that issue.
- Once my agent has full power to act under this document, my agent may request, receive, and review any information, oral or written, regarding my physical or mental health, including, but not limited to, medical and hospital records and other protected health information, and consent to disclosure of this information.
- For all purposes related to this document, my agent is my personal representative under the Health Insurance Portability and Accountability Act (HIPAA). My agent may sign, as my personal representative, any release forms or other HIPAA-related materials.

E. 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) (Month/Day/Year)

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) (Month/Day/Year)

Telephone Number(s): ______________________

______________________________ ______________

(Signature of Witness) (Month/Day/Year)

Telephone Number(s): ______________________

(**Note:** Anyone selected as a health care agent in Part I may not be a witness. Also, at least one of the 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. Maryland law does not require this document to be notarized.)