HEALTH CARE DIRECTIVE OF

_____

1. Purpose of the Form. I, _____, residing at _____, Date of Birth _____, wish and expect to the extent that I am able, to be fully informed about and to participate in any and all decision-making regarding my health care, including any procedures that may be used to prolong or sustain my life. If I lack decision-making capacity to make a health care decision, my health care agent may make decisions concerning my health care, including the withholding or withdrawing of life-sustaining and life-prolonging procedures, in accordance with any instructions I have given my agent or in my best interests if I have not made my health care wishes known.

2. Appointment of Health Care Agent and Alternate Health Care Agents. I appoint my _____, _____, residing at _____, phone number_____, as my health care agent. If for any reason he/she is not reasonably available to serve, I appoint my _____, _____, residing at _____,phone number_____, as my agent under this Health Care Directive. I designate the individual appointed as my health care agent and the individual appointed as my first alternate agent as my personal representatives for purposes of the Health Insurance Portability and Accountability Act of 1995. My personal representatives may act on my behalf in receiving and authorizing the use and disclosure of protected health information.

3. Powers of Agent.

3.1 My agent has the power to make any health care decision for me when, in the judgment of my attending physician, I lack decision-making capacity. This power includes the power to give consent, to refuse consent, or to withdraw consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect my physical or mental condition, including giving me food or water by artificial means. My agent has the power, where consistent with the laws of this state, to make a health care decision to withhold or stop health care necessary to keep me alive.

3.2 My agent must act consistently with my wishes as stated in this document or as I have otherwise made known to my agent.

To the extent not inconsistent with this document, I direct that my agent carry out my wishes as expressed in any Health Care Declaration ("Living Will") if I am in a terminal condition and cannot express my wishes.

3.3 My agent has the same right as I would have to receive, review, and obtain copies of my medical records and to consent to disclosure of those records. Specifically, I grant my agents the power to review all of my medical records and have the same rights that I would have to give my medical records to other people. I expressly waive all medical privilege in favor of my designated agent(s) and personal representatives appointed by me under this Health Care Directive. When in the process of determining my incapacity, if necessary, or to give effect to this waiver of my medical privilege, all individually identifiable health information and medical records may be released to the person who is nominated as my health care agent or, where applicable, my alternate health care agent, to include any written opinion relating to my incapacity that the person so nominated may have requested. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (aka HIPAA), 42 USC 1320d and 45 CFR 160-164.

3.4 My agent may choose where I live when I need health care and what personal security measures are needed to keep me safe. I would prefer to receive my health care at home, but, if not, then at a hospice or under the care of a hospice selected by me or by my agent.

4. <u>Terminal Condition Instructions</u>. This is my "Living Will." If I am in a terminal condition and cannot express my wishes, I wish to be allowed to die naturally and not be kept alive by artificial means or heroic measures. I do not want any medical treatment that will not substantially improve my condition or help me recover, but will only postpone the moment of my death. However, I want whatever care is appropriate to keep me as comfortable and as free of pain as is reasonably possible, including hydration and the administration of pain relieving drugs and surgical or medical procedures calculated to relieve my pain, even though some drugs or procedures may hasten my death and exceed accepted medical protocol.

5. Nomination of Guardian. If there is a petition for the appointment of a guardian or conservator to have authority with respect to decisions concerning life-sustaining procedures or other health care for me, I nominate, pursuant to Minnesota Statutes, the agent(s) designated in this Health Care Directive for appointment by the court as guardian or conservator of my person. I ask that the guardian/conservator be given such authority to make such health care decisions as may be permitted under Minnesota law.

6. Organ Donation after Death. [ ] I do not [ ] I wish to donate my organs, tissue and other body parts when I die.

7. Disposition of my Remains. My agent may make decisions about what will happen to my body when I die. [ ] I do [ ] I do not wish to be cremated when I die.

8. Revocation. I revoke all Living Wills, Health Care Declarations, Durable Powers of Attorney for Health Care and other written advance health care directives I have signed in the past.

Dated:_____

Signed_____

State of Minnesota)
) ss.
County of St. Louis)

In my presence on _____, the principal acknowledged his/her signature on this document or acknowledged that he/she authorized the person signing this document to sign on his/her behalf. I am not named as a health care agent or alternate health care agent in this document.

_____
Signature of Notary Public or Other Official