

**CALIFORNIA**

**ADVANCE**



**DIRECTIVES**

**Legal Documents  
To Assure Future Health Care Choices**

# **ADVANCE DIRECTIVES**

## **YOUR RIGHT TO MAKE HEALTH CARE DECISIONS UNDER THE LAW IN CALIFORNIA**

### **INTRODUCTION**

California and federal law give every competent adult, 18 years or older, the right to make their own health care decisions, including the right to decide what medical care or treatment to accept, reject or discontinue. If you do not want to receive certain types of treatment or you wish to name someone to make health care decisions for you, you have the right to make these desires known to your doctor, hospital or other health care providers, and in general, have these rights respected. You also have the right to be told about the nature of your illness in terms that you can understand, the general nature of these proposed treatments, the risks of failing to undergo these treatments and any alternative treatments or procedures that may be available to you.

However, there may be times when you cannot make your wishes known to your doctor or other health care providers. For example, if you were taken to a hospital in a coma, would you want the hospital's medical staff to know what your specific wishes are about the medical care that you want or do not want to receive.

This booklet describes what California and federal law have to say about your rights to inform your health care providers about medical care and treatment you want or do not want, and about your right to select another person to make these decisions for you if you are physically or mentally unable to make them yourself.

To make these difficult issues easier to understand, we have presented the information in the form of questions and answers. Because this is an important matter, we urge you to talk to your spouse, family, close friends, personal advisor, your doctor and to your attorney before deciding whether you want an advance directive.

### **QUESTIONS AND ANSWERS**

#### **GENERAL INFORMATION ABOUT ADVANCE DIRECTIVES**

##### **What are "Advance Directives"?**

Advance directives are documents which state your choices about medical treatment or name someone to make decisions about your medical treatment, if you are unable to make these decisions or choices yourself. They are called "advance" directives because they are signed in advance to let your doctor and other health care providers know your wishes concerning medical treatment. Through advance directives, you can make legally valid decisions about your future medical care.

California law recognizes 2 types of advance directives:

- 1) Instructions for Health Care (Living Will).
- 2) A Power of Attorney for Health Care.

### **Do I have to have an Advance Directive?**

No, it is entirely up to you whether you want to prepare any documents. But if questions arise about the kind of medical treatment that you want or do not want, advance directives may help to solve these important issues. Your doctor or any health care provider cannot require you to have an advance directive in order to receive care; nor can they prohibit you from having an advance directive. Moreover, under California law, no health care provider or insurer can charge different fees or rates depending on whether or not you have executed an advance directive.

### **What will happen if I do not make an Advance Directive?**

You will receive medical care even if you do not have any advance directives. However, there is a greater chance that you will receive more treatment or more procedures than you may want.

If you cannot speak for yourself and have not made an advance directive, your doctor or other health care providers will generally look to your family or friends for decisions about your care. But if your doctor or your health care facility is unsure or if your family members cannot agree, they may have to ask the court to appoint a person (called a conservator) to make those decisions for you.

### **How do I know what treatment I want?**

Your doctor must inform you about your medical condition and what different treatments can do for you. Many treatments have serious side effects. Your doctor must give you information, in language that you can understand, about serious problems that medical treatment is likely to cause. Often, more than one treatment might help you and different people might have different ideas on which is best. Your doctor can tell you the treatments that are available to you, but he cannot choose for you. That choice depends on what is important to you.

### **Whom should I talk to about Advance Directives?**

Before writing down your instructions, you should talk to those people closest to you and who are concerned about your care and feelings. Discuss them with your family, your doctor, friends, and other appropriate people, such as a member of your clergy or your lawyer. These are the people who will be involved with your health care if you are unable to make your own decisions.

### **When do Advance Directives go into effect?**

It is important to remember that these directives only take effect when you can no longer make your own health care decisions. As long as you are able to give "informed consent," your health care providers will rely on **YOU** and **NOT** on your advance directives.

## **What is “Informed Consent”?**

Informed consent means that you are able to understand the nature, extent and probable consequences of proposed medical treatments and you are able to make rational evaluations of the risks and benefits of those treatments as compared with the risks and benefits of alternate procedures **AND** you are able to communicate that understanding in any way.

## **How will health care providers know if I have any Advance Directives?**

All hospitals, nursing homes, home health agencies, HMOs and all other health care facilities that accept federal funds must ask if you have an advance directive, and if so, they must see that it is made part of your medical records.

## **Will my Advance Directives be followed?**

Generally, yes, if they comply with California law. Federal law requires your health care providers to give you their written policies concerning advance directives. A summary statement of those policies is provided for you at the back of this book. It may happen that your doctor or other health care provider cannot or will not follow your advance directives for moral, religious or professional reasons, even though they comply with California law. If this happens, they must immediately tell you. Then they must help you transfer to another doctor or facility that will do what you want.

## **Can I change my mind after I write an Advance Directive?**

Yes, at any time, you can cancel or change any advance directive that you have written. To cancel your directive, simply destroy the original document and tell your family, friends, doctor and anyone else who has copies that you have cancelled them. To change your advance directives, simply write and date a new one. Again, give copies of your revised document to all the appropriate parties, including your doctor.

## **Do I need a lawyer to help me make an Advance Directive?**

A lawyer may be helpful and you might choose to discuss these matters with him, but there is no legal requirement in California to do so. You may use the form that is provided in this booklet to execute your advance directives.

## **Will my California Advance Directive be honored in another state?**

The laws on advance directives differ from state to state, so it is unclear whether a California advance directive will be valid in another state. Because an advance directive is a clear expression of your wishes about medical care, it will influence that care no matter where you are admitted. However, if you plan to spend a great deal of time in another state, you might want to consider executing an advance directive that meets all the legal requirements of that state.

## **Will an Advance Directive from another state be honored in California?**

Yes. An advance directive executed in compliance with another state's laws will be honored in California to the extent permitted by California law.

## **What should I do with my Advance Directives?**

You should keep them in a safe place where your family members can get to them. Do **NOT** keep the original copies in your safe deposit box. Give copies of these documents to as many of the following people as you are comfortable with: your spouse and other family members; your doctor; your lawyer; your clergy person; and any local hospital or nursing home where you may be residing. Another idea is to keep a small wallet card in your purse or wallet which states that you have an advance directive and who should be contacted. Wallet cards are provided for you at the back of this booklet for that purpose.

## **How do California Advance Directives differ from other states?**

There are several differences:

1) Most states use 2 or more documents in order for a person to give advance instructions about his/her future health care. The California legislature, by adopting a version of the Uniform Health Care Decisions Act, has created one simplified document that covers all the elements of an advance directive.

2) California is one of the very few states that allows you to make organ donation part of your advance directive document.

3) California is one of the very few states that allows you to appoint your primary physician and your conservator in your advance directive document.

## **INSTRUCTIONS FOR HEALTH CARE (LIVING WILL)**

### **What is a “Living Will”?**

A living will (officially called “Instructions for Health Care” in California) is a document which tells your doctor or other health care providers whether or not you want life-sustaining treatments or procedures administered to you if you are in a terminal condition or a permanent unconscious state. It is called a “living will” because it takes effect while you are still living.

### **Is a “Living Will” the same as a “Will” or “Living Trust”?**

No. Wills and living trusts are financial documents which allow you to plan for the distribution of your financial assets and property after your death. A living will only deals with medical issues while you are still living. Wills and living trusts are complex legal documents and you usually need legal advice to execute them. You do not need a lawyer to complete your California living will.

### **When does a California Living Will go into effect?**

A California living will goes into effect when:

1) your doctor has a copy of it, and 2) your doctor has concluded that you are no longer able to make your own health care decisions, and 3) your doctor has also determined that you are in a terminal condition or a permanent unconscious state.

### **What are “life-sustaining” treatments?**

These are treatments or procedures that are not expected to cure your terminal

condition or make you better. They only prolong dying. Examples are mechanical respirators which help you breathe, kidney dialysis which clears your body of wastes, and cardiopulmonary resuscitation (CPR) which restores your heartbeat.

### **What is a “terminal” condition?**

A terminal condition is defined as an incurable condition for which administration of medical treatment will only prolong the dying process and without administration of these treatments or procedures, death will occur in a relatively short period of time.

### **What is a “permanent unconscious state”?**

A permanent unconscious state means that a patient is in a permanent coma caused by illness, injury or disease. The patient is totally unaware of himself, his surroundings and environment and to a reasonable degree of medical certainty, there can be no recovery.

### **Is a Living Will the same as a “Do Not Resuscitate (DNR)” order?**

No. A California living will covers almost all types of life-sustaining treatments and procedures. A “Do Not Resuscitate” order covers two types of life-threatening situations. A DNR order is a document prepared by your doctor at your direction and placed in your medical records. It states that if you suffer cardiac arrest (your heart stops beating) or respiratory arrest (you stop breathing), your health care providers are not to try to revive you by any means.

### **Will I receive medication for pain?**

Unless you state otherwise in the living will, medication for pain will be provided where appropriate to make you comfortable and will not be discontinued.

### **Does a California Living Will affect insurance?**

No. The making of a living will, in accordance with California law, will not affect the sale or issuance of any life insurance policy, nor shall it invalidate or change the terms of any insurance policy. In addition, the removal of life-support systems according to California law, shall not, for any purpose, constitute suicide, homicide or euthanasia, nor shall it be deemed the cause of death for the purposes of your insurance coverage.

## **POWER OF ATTORNEY FOR HEALTH CARE**

### **What is a Power of Attorney for Health Care (PAHC)?**

A PAHC is a legal document which allows you (the “principal”) to appoint another person (the “attorney-in-fact” or “agent”) to make medical decisions for you if you should become temporarily or permanently unable to make those decisions yourself. The person you choose as your attorney-in-fact does not have to be a lawyer.

### **Who can I select to be my Agent?**

You can appoint almost any adult to be your agent. You should select a person(s)

knowledgeable about your wishes, values, religious beliefs, in whom you have trust and confidence and who knows how you feel about health care. You should discuss the matter with the person(s) you have chosen and make sure that they understand and agree to accept the responsibility.

You can select a member of your family, such as your spouse, child, brother or sister, or a close friend. If you select your spouse and then become divorced, the appointment of your spouse as your agent is revoked.

The following people **CANNOT** be appointed as your agent:

1) Your supervising health care provider; 2) An employee of any health care institution where you are receiving care; 3) An operator or employee of a community care facility or a residential care facility for the elderly where you are receiving care.

However, the employees listed above may be appointed as your agent if he/she is either;

1) Related to you by blood, marriage or adoption; or 2) Employed by the same health care institution, community care facility, or residential care facility for the elderly that employs you.

### **When does the PAHC take effect?**

The PAHC only becomes effective when you are temporarily or permanently unable to make your own health care decisions and your agent consents to start making those decisions. Your agent will begin making decisions after your doctors have decided that you are no longer able to make them. Remember, as long as you are able to make treatment decisions, you have the right to do so.

### **What decisions can my Agent make?**

Unless you limit his/her authority in the PAHC, your agent will be able to make almost every treatment decision in accordance with accepted medical practice that you could make, if you were able to do so. If your wishes are not known or cannot be determined, your agent has the duty to act in your best interest in the performance of his/her duties. These decisions can include authorizing, refusing or withdrawing treatment, even if it means that you will die. As you can see, the appointment of an agent is a very serious decision on your part.

### **Are there any decisions my Agent cannot make?**

Yes, California law prohibits your agent from:

1) Committing you to a mental health treatment facility; 2) Authorizing convulsive treatment therapy; 3) Authorizing psychosurgery; 4) Authorizing sterilization; or 5) Authorizing abortion.

### **What happens if I regain the capacity to make my own decisions?**

If your doctor determines that you have regained the capacity to make or to communicate health care decisions, then two things will happen:

1) Your agent's authority will end; and 2) Your consent will be required for treatment.

If your doctor later determines that you no longer have the capacity to make or to communicate health care decisions, then your agent's authority will be restored.

### **Can there be more than one Agent?**

Yes. While you are not required to do so, you may designate alternates who may also act for you if your primary agent is unavailable, unable or unwilling to act. Your alternates have the same decision-making powers as the primary agent. It is generally a good idea to select at least one alternate agent.

### **Can my Agent resign?**

Yes. Your agent and your alternates can resign at any time by giving written notice to you, your doctor or the hospital or nursing home where you are receiving care.

### **Can my Agent be legally liable for decisions made on my behalf?**

No. Your health care agent or your alternate agents cannot be held liable for treatment decisions made in good faith on your behalf. Also, he/she cannot be held liable for costs incurred for your care, just because he or she is your agent.

### **Does an Advance Health Care Directive have to be signed and witnessed?**

Yes, you must sign (or have someone sign the directive in your presence and at your direction, if you are unable to sign) and date it. Then it must be witnessed by 2 qualified adults or notarized.

The only people who **CANNOT** witness your signature of the directive are:

1) Your treating health care provider or an employee of your treating health care provider; 2) The person(s) you appointed as your agent or alternate agent; 3) An operator or an employee of a community care facility; or 4) An operator or an employee of a residential care facility for the elderly.

In addition, at least one of the witnesses must not be related to you by blood, marriage or adoption, or be entitled to any part of your estate upon your death. Also, if you are a resident of a skilled nursing facility, at least one of the witnesses must be a patient advocate or ombudsman designated by the State Department of Aging.

### **Can I register my Advance Health Care Directive with the California state government?**

Yes. California law now allows you to register, amend or revoke the information in your Advance Health Care Directive with the California Secretary of State. This information can then be obtained by your health care providers, public guardians and other authorized individuals from the Secretary of State's office.

You may phone or write the Special Filings Unit, California Secretary of State, P.O. Box 944225, Sacramento, CA 94244-2250 (916-653-4984) to obtain the form or any information. The current fee for filing is \$15.00 and \$7.00 to amend the information. There is no fee to revoke the information. You do **NOT** have to register the information with the Secretary of State for your Advance Health Care Directive to be valid.



# CALIFORNIA ADVANCE HEALTH-CARE DIRECTIVE

## (CALIFORNIA PROBATE CODE SECTION 4701)

### EXPLANATION OF THIS DOCUMENT

You have the right to give instructions about your own health care. You also have the right to name someone else to make health care decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding donation of organs and the designation of your primary physician. If you use this form, you may complete or modify all or any part of it. You are free to use a different form.

**PART 1** of this form is a power of attorney for health care. Part 1 lets you name another individual as agent to make health care decisions for you if you become incapable of making your own decisions or if you want someone else to make those decisions for you now even though you are still capable. You may also name an alternate agent to act for you if your first choice is not willing, able or reasonably available to make decisions for you. (Your agent may not be an operator or employee of a community care facility or a residential care facility where you are receiving care, or your supervising health care provider or employee of a health care institution where you are receiving care, unless your agent is related to you or is a coworker.)

Unless the form you sign limits the authority of your agent, your agent may make all health care decisions for you. This form has a place for you to limit the authority of your agent. You need not limit the authority of your agent if you wish to rely on your agent for all health care decisions that may have to be made. If you choose not to limit the authority of your agent, your agent will have the right to:

- a) consent or refuse consent to any care, treatment, service or procedure to maintain, diagnose or otherwise affect a physical or mental condition.
- b) select or discharge health care providers and institutions.
- c) approve or disapprove diagnostic tests, surgical procedures, and programs of medication.
- d) direct the provision, withholding or withdrawal of artificial nutrition and hydration and all other forms of health care, including cardiopulmonary resuscitation.
- e) make anatomical gifts, authorize an autopsy, and direct disposition of remains.

**PART 2** of this form lets you give specific instructions about any aspect of your health care whether or not you appoint an agent. Choices are provided for you to express your wishes regarding the provision, withholding or withdrawal of treatment to keep you alive, as well as the provision of pain relief. Space is also provided for you to add to the choices you have made or for you to write out any additional wishes. If you are satisfied to allow your agent to determine what is best for you in making end-of-life decisions, you need not fill out Part 2 of this form.

**PART 3** of this form lets you express an intention to donate your bodily organs and tissues following your death.

**PART 4** of this form lets you designate a physician to have primary responsibility for your health care.

After completing this form, sign and date the form at the end. The form must be signed by two qualified witnesses or acknowledged before a notary public. Give a copy of the signed and completed form to your physician, to any other health care providers you may have, to any health care institution at which you are receiving care and to any health care agents you have named. You should talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take the responsibility.

You have the right to revoke this advance health care directive or replace this form at any time.

**PART 1**  
**POWER OF ATTORNEY FOR HEALTH CARE**

**DESIGNATION OF AGENT**

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

\_\_\_\_\_  
(Name of the individual you choose as your Agent)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(City)

\_\_\_\_\_  
(State)

\_\_\_\_\_  
(Zip Code)

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

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

**DESIGNATION OF ALTERNATE AGENTS (OPTIONAL)**

If I revoke my agent's authority or if my agent is not willing, able or reasonably available to make a health care decision for me, I designate as my first alternate agent:

\_\_\_\_\_  
(Name of the individual you choose as your First Alternate Agent)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(City)

\_\_\_\_\_  
(State)

\_\_\_\_\_  
(Zip Code)

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

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

If I revoke the authority of my agent and first alternate agent or if neither is willing, able or reasonably available to make a health care decision for me, I designate as my second alternate agent:

\_\_\_\_\_  
(Name of the individual you choose as your Second Alternate Agent)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(City)

\_\_\_\_\_  
(State)

\_\_\_\_\_  
(Zip Code)

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

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

**AGENT'S AUTHORITY**

My agent is authorized to make all health care decisions for me, including decisions to provide, withhold or withdraw artificial nutrition and hydration and all other forms of health care to keep me alive, except as I state here:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(Add additional sheets if needed.)

## WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE

My agent's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions, unless I mark the following box. If I mark this box [  ], my agent's authority to make health care decisions for me takes effect immediately.

### AGENT'S OBLIGATION

My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

### AGENT'S POSTDEATH AUTHORITY

My agent is authorized to make anatomical gifts, authorize an autopsy, and direct disposition of my remains, except as I state here or in Part 3 of this form:

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(Add additional sheets if needed.)

### NOMINATION OF CONSERVATOR

If a conservator of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able or reasonably available to act as conservator, I nominate the alternate agents whom I have named, in the order designated.

## PART 2

### INSTRUCTIONS FOR HEALTH CARE

*(If you do fill out this part of the form, you may strike any wording you do not want.)*

#### END-OF-LIFE DECISIONS

I direct that my health care providers and others involved in my care provide, withhold or withdraw treatment in accordance with the choice I have marked below:

[  ] a) Choice Not To Prolong Life

I do not want my life to be prolonged if (i) I have an incurable and irreversible condition that will result in my death within a relatively short time, (ii) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness or (iii) the likely risks and burdens of treatment would outweigh the expected benefits, **OR**

[  ] b) Choice To Prolong Life

I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

## RELIEF FROM PAIN

Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death:

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(Add additional sheets if needed.)

## OTHER WISHES

*(If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.)*

I direct that:

---

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(Add additional sheets if needed.)

## PART 3

### DONATION OF ORGANS AT DEATH (OPTIONAL)

Upon my death (mark applicable box)

(a) I give any needed organs, tissues or parts, OR

(b) I give the following organs, tissues or parts only \_\_\_\_\_  
\_\_\_\_\_

(c) My gift is for the following purposes (strike any of the following you do not want)  
(i) Transplant, (ii) Therapy, (iii) Research, (iv) Education

## PART 4

### DESIGNATION OF PRIMARY PHYSICIAN(S) (OPTIONAL)

I designate the following physician as my primary physician:

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(Name of Physician)

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(Address) (City) (State) (Zip Code)

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(Phone)

If the physician I have designated above is not willing, able or reasonably available to act as my primary physician, I designate the following physician as my primary physician:

---

(Name of Physician)

---

(Address) (City) (State) (Zip Code)

---

(Phone)

## OTHER PROVISIONS

I revoke any prior Advance Health Care Directive.

This Advance Health Care Directive is intended to be valid in any jurisdiction in which it is presented.

This Advance Health Care Directive shall become effective upon my disability or incapacity, unless I have checked the appropriate box in part 1, in which case, my agent's authority becomes effective immediately.

Photocopies of this Advance Health Care Directive may be relied upon as though they were the original.

## SIGNATURE OF PRINCIPAL

*(Sign and date the form here)*

_____	_____
(Date)	(Sign Your Name)
_____	_____
(Address)	(Print Your Name)
_____	_____
(City) (State) (Zip Code)	(Date of Birth)

## SIGNATURES OF WITNESSES OR NOTARY

*(This power of attorney will not be valid for making health care decisions unless it is either (a) signed by two qualified adult witnesses who are personally known to you and who are present when you sign or acknowledge your signature; or (b) acknowledged before a notary public in the state.)*

### ALTERNATIVE NO. 1

### WITNESS STATEMENT

I declare under penalty of perjury under the laws of California (1) that the individual who signed or acknowledged this advance health care directive is personally known to me, or that the individual's identity was proven to me by convincing evidence, (2) that the individual signed or acknowledged this advance directive in my presence, (3) that the individual appears to be of sound mind and under no duress, fraud, or undue influence, (4) that I am not a person appointed as agent by this advance directive, and (5) that I am not the individual's health care provider, an employee of the individual's health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility for the elderly, nor an employee of an operator of a residential care facility for the elderly.

First Witness

(Print Name)

Second Witness

(Print Name)

\_\_\_\_\_

(Address)

\_\_\_\_\_

(Address)

\_\_\_\_\_

(City) (State)

\_\_\_\_\_

(City) (State)

\_\_\_\_\_

(Signature of Witness)

\_\_\_\_\_

(Signature of Witness)

\_\_\_\_\_

(Date)

\_\_\_\_\_

(Date)

**ADDITIONAL STATEMENT OF WITNESSES**

*(At least one of the above witnesses must also sign the following declaration.)*

I further declare under penalty of perjury under the laws of California that I am not related to the individual executing this advance health care directive by blood, marriage, or adoption, and to the best of my knowledge, I am not entitled to any part of the individual's estate upon his or her death under a will now existing or by operation of law.

\_\_\_\_\_  
(Signature of Witness)

\_\_\_\_\_  
(Signature of Witness)

**SPECIAL WITNESS REQUIREMENT**

*(The following statement is required only if you are a patient in a skilled nursing facility—a health care facility that provides the following basic services: skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis. The patient advocate or ombudsman must sign the following statement:)*

**STATEMENT OF PATIENT ADVOCATE OR OMBUDSMAN**

I declare under penalty of perjury under the laws of California that I am a patient advocate or ombudsman as designated by the State Department of Aging and that I am serving as a witness as required by Section 4675 of the Probate Code.

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Sign Your Name)

\_\_\_\_\_  
(Address, City, State)

\_\_\_\_\_  
(Print Your Name)

**ALTERNATIVE NO. 2  
NOTARY PUBLIC**

*(YOU MAY USE THIS CERTIFICATE OF ACKNOWLEDGMENT BEFORE A NOTARY PUBLIC INSTEAD OF THE STATEMENT OF WITNESSES.)*

State of California )

) ss.

County of \_\_\_\_\_ )

On \_\_\_\_\_ before me, \_\_\_\_\_,  
(here insert name and title of the officer)

personally appeared \_\_\_\_\_, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) 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. (Civil Code Section 1189)

\_\_\_\_\_  
(Signature of Notary Public)

NOTARY SEAL

# A SUMMARY STATEMENT OF HEALTH CARE POLICIES REGARDING PATIENTS' RIGHTS OF SELF-DETERMINATION

*(Since a summary like this cannot answer all possible questions or cover every circumstance, you should discuss any remaining questions with a representative of this health care facility.)*

1. Prior to the start of any procedure or treatment, the physician shall provide the patient with whatever information is necessary for the patient to make an informed judgment about whether the patient does or does not want the procedure or treatment performed. Except in an emergency, the information provided to the patient to obtain the patient's consent shall include, but not necessarily be limited to, the intended procedure or treatment, the potential risks, and the probable length of disability. Whenever significant alternatives of care or treatment exist, or when the patient requests information concerning alternatives, the patient shall be given such information. The patient shall have the right to know the person responsible for all procedures and treatments.

2. The patient may refuse medical treatment to the extent permitted by law. If the patient refuses treatment, the patient will be informed of significant medical consequences that may result from such action.

3. The patient will receive written information concerning his or her individual rights under state law to make decisions concerning medical care.

4. The patient will be given information and the opportunity to make advance directives -- including, but not limited to, a California Instructions for Health Care and/or a Power of Attorney for Health Care.

5. The patient shall receive care regardless of whether or not the patient has or has not made an advance directive.

6. The patient shall have his or her advance directive(s), if any has been created, made a part of his or her permanent medical record.

7. The patient shall have all of the terms of his or her advance directive(s) complied with by the health care facility and caregivers to the extent required or allowed by law.

8. The patient shall be transferred to another doctor or health care facility if his or her doctor(s), or agent of his or her doctor(s), or the health care facility cannot respect the patient's advance directive requests as a matter of "conscience."

9. The patient shall receive the name, phone number and address of the appropriate state agency responsible for receiving questions and complaints about these advance directive policies.

# WALLET CARDS FOR CALIFORNIA ADVANCE DIRECTIVES

Cut out and complete the cards below. Put one card in the wallet or purse you carry most often, along with your driver's license or health insurance card. You may keep the second card on your refrigerator, in your motor vehicle glove compartment, a spare wallet or purse, or other easy-to-find place.



**ATTN: CALIFORNIA HEALTH CARE PROVIDERS**

I have created the following Advance Directives:  
(Check one or both)

California Instructions for Health Care  
 Power of Attorney for Health Care

Please contact \_\_\_\_\_ (Name)  
at \_\_\_\_\_ (Address)  
and \_\_\_\_\_ (Telephone) for more information.

\_\_\_\_\_  
(Date) \_\_\_\_\_ (Signature)



**CALIFORNIA ORGAN DONOR CARD**

I have donated an anatomical gift, if medically acceptable, in my California Advance Health Care Directive dated \_\_\_\_\_.

Please contact \_\_\_\_\_ (Name)  
\_\_\_\_\_ (Address)  
\_\_\_\_\_ (Telephone) for more information.

\_\_\_\_\_  
(Date) \_\_\_\_\_ (Signature)



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\_\_\_\_\_  
(Date) \_\_\_\_\_ (Signature)

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