Triage Cancer Estate Planning Toolkit: Mississippi

Part II: Understanding Estate Planning Documents in Your State

State Laws About Wills

A will is a legal document that provides instructions for what you would like to have happen to your property upon death. A will is also a place where parents can name a guardian for any minor children or adult children with developmental disabilities.

Mississippi probate courts accept written, holographic, and oral wills. To make a valid written will in Mississippi:

1. You need to be in the right state of mind to create a will. This means you need to be:
    - At least 18 years old
    - Of "sound mind" (meaning you know what you're doing)
2. You need to sign the will, in front of two witnesses who are not included in your will.
3. Your will does not need to be notarized to be legal in Mississippi. However, you can make your will "self-proving," or accepted in probate court without the court needing to contact your witnesses. To do this, you and your witnesses must sign an affidavit affirming the will in front of a notary.

Due to the COVID-19 pandemic, Mississippi now allows you to execute your will remotely (e.g. witness the signing of a will by teleconferencing). However, before you execute your will remotely, you should check your state's laws to make sure that this is still allowed at the time you are executing your will.

A holographic will is one that is handwritten by you. To make a valid holographic will in Mississippi:

1. You need to be in the right state of mind to create a will. This means you need to be:
    - At least 18 years old
    - Of "sound mind" (meaning you know what you're doing)
2. Your will must be written in your handwriting and you must sign and date it.

If you make a holographic will, it does not need to be signed by witnesses. However, most estate planning experts do not recommend relying on holographic wills because it is more difficult to prove that they are valid in probate court.

Oral wills are only valid in Mississippi if made by someone with a terminal illness, at their home where they have resided ten days before death. This will can only be used to pass down assets worth less than $100, unless it can be proved by two witnesses that you intended for this to be your will. Oral wills cannot be brought to probate court less than 14 days after you pass away. While oral wills are useful for extreme circumstances, experts recommend creating a written will if you can.

State Laws About Financial Powers of Attorney

A power of attorney for financial affairs is a legal document where you (the principal) name a trusted adult (the agent) who is authorized to make financial decisions on your behalf.

In Mississippi, a general durable power of attorney allows you to appoint someone (your “attorney-in-fact”) to make financial decisions for you. This could include managing all of your property, accessing your tax records, entering safety deposit boxes on your behalf, and taking any other actions they think are appropriate for your well-being. This document should include the words “This power of attorney shall not be affected by subsequent disability or incapacity of the principal, or lapse of time,'' or ''This power of attorney shall become effective upon the disability or incapacity of the principal.'' The first statement indicates that you want this document to go into effect upon you signing, and the second indicates that your agent should take over if you become incapacitated.

Part III includes a sample form.

State Laws About Advance Health Care Directives

An advance health care directive is a legal document you can use to provide written instructions, or state preferences, about your medical care in case you become unable to communicate. In Mississippi, this document contains five parts:

1. **Power of Attorney for Health Care.** You can use this form to appoint someone (an agent) to make decisions about your medical care for you, if you become unable to speak for yourself. You can also choose an alternate person if the first person you appoint is not available. This document takes effect when your primary physician determines you can no longer understand or communicate your preferences for health care. If you are still able to make these decisions, but would like someone else to make them for you, you can indicate that on this form. Unless they are related to you, are your registered domestic partner, or a co-worker, your agent cannot be the operator or an employee of a community care or residential care facility where you are receiving care.
2. **Instructions for Health Care:** Sometimes called a “living will,” this document lets you indicate your preferences for health care if you become unable to speak for yourself and permanently unconscious or terminally ill. This includes instructions for life-prolonging procedures, artificial nutrition and hydration, and relief from pain.
3. **Anatomical Gift at Death:** You can indicate whether or not you would like to make an organ or tissue donation.
4. **Primary Physician:** You can use this form to designate a physician you would like to be primarily responsible for your health care.
5. **Signature and Witnessing Provisions:** You must sign the AHCD in front of two qualified witnesses or a notary. Your witnesses must be at least 18 years old, and cannot be your agent, health care provider, or an employee of your provider. One of your witnesses cannot be related to you by blood, marriage, or adoption, or included in your will.

If you change your mind about who you would like to be your agent, you can change this person by telling your supervising health care provider or writing a letter expressing that you would like to revoke their appointment.

If you appoint your spouse as your agent, this will be automatically revoked if your marriage dissolves.

You can indicate that you would like to change any other instruction included in your AHCD at any time. You can simply tell your physician you would like to revoke or change your AHCD, do so in writing, or just tear up this directive.

State Laws About POLST/MOLST

A physician order for life-sustaining treatment (POLST) is a medical order completed by a seriously ill person and signed by a physician. In Mississippi, this form is called a physician order for scope of treatment (POST). The POST does not replace an advance directive. You can complete a POST form with your doctor.

This form lets you indicate your preferences for:

- Cardiopulmonary resuscitation order (also known as a "Do not resuscitate," or DNR order)
- Medical Interventions, ranging from all medical and surgical treatments available to prolong your life, selective treatments to restore your health while avoiding burdensome procedures, or comfort-focused treatments to manage symptoms and allow natural death
- Use of antibiotics
- Medically assisted nutrition, or food and hydration offered through surgically-placed tubes
- Additional orders or instructions for your care

This form will not expire, so it is important for you and your physician to review it regularly to make sure it still reflects your wishes.

Part III includes a sample POST form.

State Laws About Funeral Designation Forms

Funeral designation forms allow you to tell your loved ones what you would like to happen to your remains after you pass away. These forms can be used to choose someone to control what happens to your remains after your death, specify what you would like to have happen, and other wishes depending on your state.

Mississippi does not have a dedicated funeral designation form, but you can indicate other preferences for your remains in an advance health care directive.

State Laws About Death with Dignity

"Death with Dignity" laws, or physician-assisted dying/aid-in-dying laws, allow certain terminally ill people to voluntarily and legally request and receive a prescription medication from their physician to hasten their death in a peaceful, humane, and dignified way. By adding a voluntary option to the continuum of end-of-life care, these laws can give you dignity, control, and peace of mind during your final days with family and loved ones.

Mississippi does not have a death with dignity law. But, you can indicate other decisions related to end-of-life care in an advance health care directive.

Federal Law About HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that protects the privacy of your health information. HIPAA does allow your protected health information to a be shared with your personal representative who has authority to make health care decisions for you (i.e., your health care agent or proxy).

To guarantee your agent's access to information, a HIPAA authorization form should be signed and dated by you. Also, it must identify the information to be disclosed, the purpose of the disclosure, the recipients of the information, and an expiration date. This means that any advance health care directives should be clear about the scope of your agent's authority to receive protected health care information.

You can revoke a HIPAA authorization form at any time by notifying your health care provider in writing.

Part III of this toolkit includes a sample HIPAA authorization form. For more information: www.cdc.gov/phlp/publications/topic/hipaa.html.

Triage Cancer Estate Planning Toolkit: Mississippi

Part III: Your State's Estate Planning Forms

- Power of Attorney for Financial Affairs
- Advance Health Care Directive
- Physician Order for Scope of Treatment (POST)
- HIPAA Authorization Form

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Part III: Your State's Estate Planning Forms

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Power of Attorney for Financial Affairs

MISSISSIPPI
GENERAL POWER OF ATTORNEY FORM

I. NOTICE - This legal document grants you (Hereinafter referred to as the "Principal") the right to transfer unlimited financial powers to someone else (Hereinafter referred to as the "Attorney-in-Fact"), unlimited financial powers are described as: all financial decision making power legal under law. The Principal's transfer of financial powers to the Attorney-in-Fact are granted upon authorization of this agreement, and DO NOT stay in effect in the event of incapacitation by the Principal (incapacitation is described in Paragraph II). This agreement does not authorize the Attorney-in-Fact to make medical decisions for the Principal. The Principal continues to retain every right to all their financial decision making power and may revoke this General Power of Attorney Form at anytime. The Principal may include restrictions or requests pertaining to the financial decision making power of the Attorney-in-Fact. It is the intent of the Attorney-in-Fact to act in the Principal's wishes put forth, or, to make financial decisions that fit the Principal's best interest. All parties authorizing this agreement must be at least 18 years of age and acting under no false pressures or outside influences. Upon authorization of this General Power of Attorney Form, it will revoke any previously valid General Power of Attorney Form.

II. INCAPACITATION – The powers granted to the Attorney-in-Fact by the Principal in this General Power of Attorney Form DO NOT stay in effect upon incapacitation by the Principal, incapacitation is describes as: A medical physician stating verbally or in writing that the Principal can no longer make decisions for them self.

III. REVOCATION - The Principal has the right to revoke this General Power of Attorney Form at anytime. Any revocation will be effective if the Principal either:

A. Authorizes a new General Power of Attorney Form.
B. Authorizes a Power of Attorney Revocation Form.

IV. WITNESS & NOTARY - This document is not valid as a General Power of Attorney unless it is acknowledged before a notary public or is signed by at least two adult witnesses who are present when the Principal signs or acknowledges the Principal's signature. It is recommended to have this General Power of Attorney Form notarized.

V. PRINCIPAL - I, _____, residing at
Name of Principal

_____
Street Address of Principal

City of _____, State of _____, appoint
City of Principal *State of Principal*
the following as my Attorney-in-Fact, whom I trust with any and all my financial decision making power immediately upon the authorization of this form:

VI. ATTORNEY-IN-FACT - _____, residing at
Name of Attorney-in-Fact

_____
Street Address of Attorney-in-Fact

City of _____, State of _____ grant
City of Attorney-in-Fact *State of Attorney-in-Fact*
the Attorney-in-Fact the legal authority to act on my behalf for any power legal under law in regard to my financial decisions under the State of

_____.
State

VII. SUCCESSOR ATTORNEY-IN-FACT (*Optional)* – If the Attorney-in-Fact named above cannot or is unwilling to serve, then I appoint _____,
Name of Successor Attorney-in-Fact
residing at

_____
Street Address of Successor Attorney-in-Fact

City of _____, State of _____ grant
City of Successor Attorney-in-Fact *State of Successor Attorney-in-Fact*

the Attorney-in-Fact the legal authority to act on my behalf for any power legal under law in regard to my financial decisions under the State of

_____.
State

VIII. TERMS & CONDITIONS – Upon authorization by all parties, the Attorney-in-Fact accepts their designation to act in the Principal's best interests for all financial decisions legal under law.

IX. THIRD PARTIES – I, the Principal, agree that any third party receiving a copy via: physical copy, email, or fax that I, the Principal, will indemnify and hold harmless any and all claims that may be put forth in reference to this Durable Power of Attorney Form.

X. COMPENSATION – The Attorney-in-Fact agrees not to be compensated for acting in the presence of the Principal. The Attorney-in-Fact may be, but not entitled to, reimbursement for all: food, travel, and lodging expenses for acting in the presence of the Principal.

XI. DISCLOSURE - I intend for my attorney-in-fact under this Power of Attorney to be treated, as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records. 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

XII. PRINCIPAL'S SIGNATURE - I, _____, the Principal,
Printed Name of Principal

sign my name to this power of attorney this _____ day of
Day
_____ and, being first duly sworn, do declare to the
Month
undersigned authority that I sign and execute this instrument as my power of attorney and that I sign it willingly, or willingly direct another to sign for me, that I execute it as my free and voluntary act for the purposes expressed in the power of attorney and that I am eighteen years of age or older, of sound mind and under no constraint or undue influence.

_____
Signature of Principal

XIII. ATTORNEY-IN-FACT'S SIGNATURE - I, _____
Name of Attorney-in-Fact
have read the attached power of attorney and am the person identified as the attorney-in-fact for the principal. I hereby acknowledge and accept my appointment as Attorney-in-Fact and that when I act as agent I shall exercise the powers for the benefit of the principal; I shall keep the assets of the principal separate from my assets; I shall exercise reasonable caution and prudence; and I shall keep a full and accurate record of all actions, receipts and disbursements on behalf of the principal.

_____ _____
Signature of Attorney-in-Fact *Date*

SUCCESSOR ATTORNEY-IN-FACT'S SIGNATURE *(Optional)* -

I, _____ have read the attached power of
Name of successor Attorney-in-Fact
attorney and am the person identified as the successor attorney-in-fact for the principal. I hereby acknowledge that I accept my appointment as Successor Attorney-in-Fact and that, in the absence of a specific provision to the contrary in the power of attorney, when I act as agent I shall exercise the powers for the benefit of the principal; I shall keep the assets of the principal separate from my assets; I shall exercise reasonable caution and prudence; and I shall keep a full and accurate record of all actions, receipts, and disbursements on behalf of the principal.

_____ _____
Signature of Successor Attorney-in-Fact *Date*

Notary Acknowledgement (*Must be completed by Notary*)

State of _____ County of _____ Subscribed, Sworn and acknowledged before me by _____, the Principal, and subscribed and sworn to before me by _____, witness, this _____ day of _____.

_____
Notary Signature

Notary Public
In and for the County of _____
State of _____
My commission expires: _____ Seal

Acknowledgement and Acceptance of Appointment as Attorney-in-Fact

I, _____ have read the attached power of attorney
Name of Attorney-in-Fact
and am the person identified as the attorney-in-fact for the principal. I hereby acknowledge that accept my appointment as Attorney-in-Fact and that when I act as agent I shall exercise the powers for the benefit of the principal; I shall keep the assets of the principal separate from my assets; I shall exercise reasonable caution and prudence; and I shall keep a full and accurate of all actions, receipts and disbursements on behalf of the principal.

_____ _____
Signature of Attorney-in-Fact *Date*

Acceptance of Appointment as successor Attorney-in-Fact

I, _____ have read the attached power of
Name of successor Attorney-in-Fact
attorney and am the person identified as the successor attorney-in-fact for the principal. I hereby acknowledge that I accept my appointment as Successor Attorney-in-Fact and that, in the absence of a specific provision to the contrary in the power of attorney, when I act as agent I shall exercise the powers for the benefit of the principal; I shall keep the assets of the principal separate from my assets; I shall exercise reasonable caution and prudence; and I shall keep a full and accurate record of all actions, receipts, and disbursements on behalf of the principal.

_____ _____
Signature of Successor Attorney-in-Fact *Date*

Witness Attestation

I, _____, the first witness, and I _____
Printed Name of First Witness *Printed Name of Second Witness*
the second witness, sign my name to the foregoing power of attorney being first duly sworn and do not declare to the undersigned authority that the principal signs and executed this instrument as him or her, and that I, in the presence and hearing of the principal, sign this power of attorney as witness to the principal's signing and that to the best of my knowledge the principal is eighteen years of age or older, of sound mind and under no constraint or undue influence.

_____ _____
Signature of First Witness *Signature of Second Witness*

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Part III: Your State's Estate Planning Forms

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Advance Health Care Directive

Mississippi Advance Directive
Durable Power of Attorney for Health Care and Living Will

This advance directive form is an official document where you can write down your wishes for your healthcare. If you can't make health care decisions for yourself, this advance directive can help guide the people who will make decisions for you.

You can use this form to:

- Name specific people to make health care decisions for you
- Describe your preferences for how you want to be treated
- Describe your preferences for medical care, long-term care, or other types of healthcare

If you do not choose a healthcare decision maker and are too sick to make your own decisions, your care team will turn to your family to make decisions for you according to Mississippi law in the following order: (1) spouse; (2) adult children (all are equal, majority rules); (3) parents; (4) adult brothers and sisters (all are equal, majority rules); (5) any next closest relative; (6) any competent adult who has been known to care for you. A conservator or guardian by court order overrides any of the above.

PART 1: YOUR PERSONAL INFORMATION

YOUR NAME *(Last, First, Middle)*:		
YOUR STREET ADDRESS, CITY, STATE, ZIP:		
HOME PHONE:	WORK PHONE:	CELL PHONE:

Primary Care Providers

NAME	CLINIC	OFFICE PHONE NUMBER
STREET ADDRESS, CITY, STATE, ZIP		

If the person named above can't or doesn't want to make decisions for me, or is not reasonably available, I appoint the person named below as my primary care provider:

NAME	CLINIC	OFFICE PHONE NUMBER
STREET ADDRESS, CITY, STATE, ZIP		

PART 2: DURABLE POWER OF ATTORNEY FOR HEALTH CARE

This section of the advance directive form is called a Durable Power of Attorney for Health Care. It lets you appoint a specific person to make health care decisions for you if you are too sick to make decisions for yourself. This person will be called your Health Care Agent.

Your Health Care Agent

- Should be someone who you trust, who knows you well, and is familiar with your values and beliefs.
- **CANNOT** be someone who works at a hospital, nursing home or similar facility where you are being treated unless you are related.

HEALTH CARE AGENT		
Place your initials in the box next to your choice.		
Initials	I designate the following individual as my agent to make healthcare decisions for me if I am unable to decide for myself.	
NAME *(Last, First, Middle)*:		Relationship to me:
STREET ADDRESS:	CITY, STATE, ZIP:	
HOME PHONE:	WORK PHONE:	CELL PHONE:

ALTERNATE HEALTH CARE AGENT		
Fill out this section if you want to appoint a second person to make health care decisions for you, in case the first person isn't willing or able to speak for you when the time comes.		
Initials	If I revoke my agent's authority, or if the person named above can't or doesn't want to make decisions for me, or is not reasonably available, I appoint the person named below as my Health Care Agent.	
NAME *(Last, First, Middle)*:		Relationship to me:
STREET ADDRESS:	CITY, STATE, ZIP:	
HOME PHONE:	WORK PHONE:	CELL PHONE:

My Healthcare Decision Maker's Authority: My healthcare decision maker can make any healthcare decisions for me, but **must** follow my wishes as expressed in Part 3, even if he/she disagrees or thinks this isn't in my best interest. My healthcare decision maker can access my personal health information and medical records, and talk with my care providers about my health. If my medical choices are not clear, he or she must make those decisions in my best interest and based on what is known of my wishes. I can revoke or limit my Agent's authority at any time.

Effective Date: My healthcare decision maker can make healthcare decisions for me **(CHOOSE ONE):**

☐ when my primary care provider or treating physician determines I cannot make my own decisions or

☐ immediately after signing this form until revoked

PART 3: LIVING WILL

This section of the advance directive form is called a Living Will. This section lets you write down how you want to be treated, in case you aren't able to decide for yourself anymore and helps others choose the care you would want.

LIFE SUPPORT MEASURES

If I am so sick that I might die soon (CHOOSE ONE):

☐ ***I do not want to receive life support treatments***. I want to focus on being comfortable.

☐ ***Try all life support treatments that my doctors think might help***.

If the treatments do not work and there is little hope of getting better (CHOOSE ONE):

☐ I want to stop life support treatments if they are not working.
☐ I want to stay on life support treatments *unless* it looks like I am suffering.
☐ I want to stay on life support treatments *even* if I look like I am suffering.

☐ Other (use additional sheets if needed):

_____
_____
_____
_____
_____

COMFORT AND PAIN RELIEF

In this section, you can indicate your preferences for comfort and pain relief. Place your initials in the box next to the statements that reflect your wishes for comfort and pain relief. **Initial all that apply.**

Initials	I want to receive maximum pain relief even if it may unintentionally cause me to die sooner.
Initials	I want to receive maximum pain relief medication even if it may result in temporary dependence if I survive, recover or rebound from my current conditions and/or hospital stay.
Initials	I want a voluntary non-opioid directive. I am refusing, at my own insistence, the offer or administration of any opioid medications including in an emergency situation where I am unable to speak for myself.

CONSENT TO DONATE

☐ I want to give away as many of my organs, eyes, and tissues as possible for the purpose of donation.

☐ I only want to give away the following organs, eyes, and/or tissues for the purpose of donation:

_____

☐ I do not want to give away my organs, eyes, or tissues.

Complete this sentence if it is true. *I am already a body donor and have filled out the required consent forms with the following facility*: _____

SPECIFIC PREFERENCES ABOUT END-OF-LIFE TREATMENTS (OPTIONAL)

CPR (Cardiopulmonary Resuscitation)	
CPR is a group of procedures used when the heart stops or breathing stops as a result of a serious illness or injury.	☐ **Yes.** I would want CPR attempted at the end of life, even if the burden may outweigh the benefits. ☐ **No.** I do not want CPR attempted

Kidney Dialysis	
Kidney dialysis uses machines to remove waste products and excess fluid from the body when the kidneys are not working well enough for a person to survive.	☐ **Yes.** I would want kidney dialysis at the end of life, even if the burden may outweigh the benefits. ☐ **No.** I do not want my life prolonged with dialysis machines.

SPECIFIC PREFERENCES ABOUT LIFE-SUPPORT TREATMENTS (OPTIONAL)

In this section, you can indicate your preferences for life support treatments in certain situations. Think about each situation described on the left and ask yourself, "In that situation, would I want to have life-support treatments?" Place your initials in the box that best describes your treatment preference. **You may complete some, all, or none of this section. Choose only one box for each statement.**

	Yes. I would want life-support treatments	**No.** I would not want life-support treatments.
If I need to use a breathing machine to survive for the rest of my life.	Initials	Initials
If I cannot eat or drink by mouth and depend on artificial feeding/hydration through a tube or IV.	Initials	Initials
If I am unconscious, in a coma, or in a vegetative state, and there is little or no chance of recovery.	Initials	Initials
If I have permanent, severe, brain damage that makes me unable to recognize my family or friends (for example, severe dementia).	Initials	Initials
If I have a permanent condition where other people must help me with my daily needs (for example, eating, bathing, toileting).	Initials	Initials
OTHER:	Initials	Initials

ADDITIONAL PREFERENCES

This section is optional. In this space you can write other important preferences for your health care that aren't described somewhere else in this document. If you need more space, you may attach extra pages and use this space to refer to the attached pages. **Be sure to initial and date every page you attach.**

_____

_____

_____

_____

_____

_____

_____

PART 4: SIGNATURES

YOUR SIGNATURE

By my signature below, I certify that this form accurately describes my preferences.	
SIGNATURE:	DATE:
NAME *(Printed or Typed)*:	

WITNESSES SIGNATURES

WITNESS #1

I declare under penalty of perjury that I personally witnessed the person signing this advance directive, that the person is known to me, and that the person appears to be of sound mind and under no duress, fraud, or undue influence. I am not appointed as Health Care Agent in this advance directive or an employee at this hospital. I am not financially responsible for the care of the person making this advance directive. To the best of my knowledge, I am not named in the person's will.	
SIGNATURE:	DATE:
NAME *(Printed or Typed)*:	
STREET ADDRESS:	CITY, STATE, ZIP:

WITNESS #2

I personally witnessed the signing of this advance directive. I am not appointed as Health Care Agent in this advance directive. I am not financially responsible for the care of the person making this advance directive. To the best of my knowledge, I am not named in the person's will. I am not related to the person by blood, marriage, or adoption.	
SIGNATURE:	DATE:
NAME *(Printed or Typed)*:	
STREET ADDRESS:	CITY, STATE, ZIP:

PART 5: SIGNATURE AND SEAL OF NOTARY PUBLIC *(OPTIONAL)*

This Advance Directive form is valid in NMHS facilities without being notarized. However, you may need to have it notarized to be legally binding outside the NMHS health care setting. Space for a Notary's signature and seal is included below.

STATE OF _____

COUNTY OF _____

On this date, _____, the Declarant, _____, personally appeared before me and having provided verifiable identification to be the Declarant whose name is subscribed to this instrument and acknowledged to me that s/he executed the same in his/her capacity, and that by his/her signature on the instrument, executed the instrument.

I declare that s/he appears to be of sound mind and not under or subject to duress, fraud or undue influence, that s/he acknowledges the execution the same to be his/her voluntary act and deed, and that I am not the advocate, attorney-in-fact, proxy, surrogate, or a successor of any such, as designated within this document, nor do I hold any interest in his/her estate through a Will or by any other means or process of law.

WITNESS my hand and seal.

_____
(Notary Signature)

My Commission Expires: _____
(Date)

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Physician Orders for Life Sustaining Treatment (POLST)

MISSISSIPPI PHYSICIAN ORDERS FOR SUSTAINING TREATMENT (POST)

- This document is based on this person's current medical condition and wishes and is to be reviewed for potential replacement in the case of a substantial change in either
- HIPAA permits disclosure of POST to other health professionals as necessary
- Any section not completed indicates preference for full treatment for that section

Patient Last Name	Patient First Name/Middle
Patient Date of Birth	Effective Date (Form must be reviewed at least annually)

A Check one

CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse AND is not breathing.

- ☐ Attempt Resuscitation (CPR)
- ☐ Do Not Attempt Resuscitation (DNR)

*When not in cardiopulmonary arrest, follow orders in **B**, **C**, and **D**.*

B Check One

MEDICAL INTERVENTIONS: If the patient has pulse AND breathing OR has pulse and is NOT breathing.

- ☐ **Full Sustaining Treatment:** Transfer to a hospital if indicated. Includes intensive care. Treatment Plan: Full treatment including life support measures. Provide treatment including the use of intubation, advanced airway interventions, mechanical ventilation, defibrillation or cardioversion as indicated, medical treatment, intravenous fluids, and comfort measures.
- ☐ **Limited Interventions:** Transfer to a hospital if indicated. Avoid intensive care. Treatment Plan: Provide basic medical treatments. In addition to care described in Comfort Measures below, provide the use of medical treatment; oral and intravenous medications; intravenous fluids; cardiac monitoring as indicated; noninvasive bi-level positive airway pressure; a bag valve mask. This option excludes the use of intubation or mechanical ventilation.
  ADDITIONAL ORDERS: (e.g., vasopressors, dialysis, etc.)_____
- ☐ **Comfort Measures Only**: Treatment Goal: Maximize comfort through use of medication by any route; keeping the patient clean, warm, and dry; positioning, wound care, and other measures to relieve pain and suffering; and the use of oxygen, suction, and manual treatment of airway obstruction as needed for comfort. Do not transfer to a hospital unless comfort needs cannot be met in the patient's current location (e.g., hip fracture).
  Other instructions:_____

C Check One

ANTIBIOTICS:

- ☐ Use antibiotics if life can be sustained
- ☐ Determine use or limitation of antibiotics when infection occurs
- ☐ Use antibiotics only to relieve pain and discomfort

Other Instructions_____

D Check One in Each of the 3 Categories

MEDICALLY ADMINISTERED FLUIDS AND NUTRITION: Administer oral fluids and nutrition if physically possible.

Directing the administration of nutrition into blood vessels if physically feasible as determined in accordance with reasonable medical judgment by selecting one (1) of the following:

- ☐ Total parenteral nutrition, long-term if indicated.
- ☐ Total parenteral nutrition for a defined trial period. Goal: _____
- ☐ No parenteral nutrition.

Directing the administration of nutrition by feeding tube if physically feasible as determined in accordance with reasonable medical judgment by selecting one (1) of the following:

- ☐ Long-term feeding tube if indicated
- ☐ Feeding tube for a defined trial period. Goal: _____
- ☐ No feeding tube

OTHER INSTRUCTIONS _____

Directing the administration of hydration if physically feasible as determined in accordance with reasonable medical judgment by selecting one (1) of the following

- ☐ Long-term intravenous fluids if indicated
- ☐ Intravenous fluids for a defined trial period. Goal: _____
- ☐ Intravenous fluids only to relieve pain and discomfort

E Check All That Apply

PATIENT PREFERENCES AS A BASIS FOR THIS POST FORM (*THIS SECTION TO BE FILLED OUT WITH PATIENT DIRECTION*)

- ☐ Patient has an advance healthcare directive (per statute § 41-41-203): ☐ YES , Date of Execution: _____

I certify that the Physician Order for Sustaining Treatment is in accordance with the advance directive.

Signature:_____ Print Name:_____ Relationship:_____

- ☐ Patient is an unemancipated minor, direction was provided by the following in accordance with §41-41-3, Mississippi Code of 1972:
  - ☐ Minor's guardian or custodian
  - ☐ Minor's parent
  - ☐ Adult brother or sister of the minor
  - ☐ Minor's grandparent, or
  - ☐ Adult who has exhibited special care and concern for minor
- ☐ Patient is an adult or an emancipated minor, direction was provided by the following in accordance with §41-41-205, 41-41-211 or 41-41-213, Mississippi Code of 1972:
  - ☐ Patient

☐ Agent authorized by patient's power of attorney for health care
☐ Guardian of the patient
☐ Surrogate designated by patient
☐ Spouse of patient (if not legally separated)
☐ Adult child of the patient
☐ Parent of the patient
☐ Adult brother or sister of the patient, or
☐ Adult who has exhibited special care and concern for the patient and is familiar with the patient's values

F

SIGNATURE OF PATIENT OR REPRESENTATIVE

Signature	Print Name	Date

SIGNATURE OF PRIMARY PHYSICIAN (POST MUST BE REVIEWED AND SIGNED BY A PHYSICIAN TO BE VALID)

Signature (**Required**)	Print Name	Date (**Required**)

HEALTH CARE PROFESSIONAL PREPARING FORM (IF OTHER THAN PATIENT'S PRIMARY PHYSICIAN)

Signature	Print Name	Contact Information	Date

G

INFORMATION FOR PATIENT OR REPRESENTATIVE OF PATIENT NAMED ON THIS FORM

The POST form is always voluntary and is usually for persons with advanced illness. POST records your wishes for medical treatment in your current state of health. Once initial medical treatment is begun and the risks and benefits of further therapy are clear, your treatment wishes may change. Your medical care and this form can be changed to reflect your new wishes at any time. However, no form can address all the medical treatment decisions that may need to be made. An advance health-care directive is recommended for all capable adults and emancipated minors, regardless of their health status. An advance directive allows you to document in detail your future health care instructions and/or name a health-care agent to speak for you if you are unable to speak for yourself.

If this form is for a minor for whom you are authorized to make health-care decisions, you may not direct denial of medical treatment in a manner that would make the minor a "neglected child" under Section 43-21-105, Mississippi Code of 1972, or otherwise violate the child abuse and neglect laws of Mississippi. In particular, you may not direct the withholding of medically indicated treatment from a disabled infant with life-threatening conditions, as those terms are defined in 42 USCS Section5106g or regulations implementing it and 42 USCS Section 5106a.

H

DIRECTIONS FOR COMPLETING AND IMPLEMENTING FORM

I. COMPLETING POST

POST must be reviewed and prepared in consultation with the patient or the patient's representative.

POST must be reviewed and signed by a physician to be valid. Be sure to document the basis for concluding the patient had or lacked capacity at the time of execution on the form in the patient's medical record. The signature of the patient or the patient's representative is required; however, if the patient's representative is not reasonably available to sign the original form, a copy of the completed form with the signature of the patient's representative must be placed in the medical record as soon as practicable and "on file" must be written on the appropriate signature on this form.

Use of original form is required. Be sure to send the original form with the patient.

There is no requirement that a patient have a POST.

II. IMPLEMENTING POST

If a health care provider or facility is unwilling to comply with the orders due to policy or personal objections, the provider or facility must not impede transfer of the patient to another provider or facility willing to implement the orders and must provide at least requested care in the meantime unless, in reasonable medical judgment, denial of requested care would not result in or hasten the patient's death.

If a minor protests a directive to deny the minor life-preserving medical treatment, the denial of treatment may not be implemented pending issuance of a judicial order resolving the conflict.

III. REVIEWING POST

This POST must be reviewed at least annually or earlier if;

a. The patient is admitted or discharged from a health care facility;
b. There is a substantial change in the patient's health status; or
c. The patient's treatment preferences change

If POST is revised or becomes invalid, draw a line through Sections A-E and write "VOID" in large letters.

IV. REVOCATION OF POST

This POST may be revoked by the patient or the patient's representative.

I

REVIEW OF POST

Review Date	Reviewer and Location of Review	MD/DO Signature (Required)	Signature of Patient or Representative (Required)	Outcome of Review (Choose one)
				☐ No Change ☐FORM VOIDED, new form completed ☐FORM VOIDED, no new form
				☐ No Change ☐FORM VOIDED, new form completed ☐FORM VOIDED, no new form

Triage Cancer Estate Planning Toolkit

⌘

Part III: Your State's Estate Planning Forms

⌘

HIPAA Authorization Form

Sample HIPAA Right of Access Form for Family Member/Friend

I, _____, direct my health care and medical services providers and payers to disclose and release my protected health information described below to:

Name: *Relationship:*

_____ _____

Contact information: _____

_____

Health Information to be disclosed upon the request of the person named above -- (Check either A or B):

- ☐ A. **Disclose** my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) **OR**
- ☐ B. **Disclose** my health record, as above, **BUT do not disclose** the following (check as appropriate):
  - ☐ Mental health records
  - ☐ Communicable diseases (including HIV and AIDS)
  - ☐ Alcohol/drug abuse treatment
  - ☐ Other (please specify):

    _____
    _____

Form of Disclosure (unless another format is mutually agreed upon between my provider and designee):

- ☐ An electronic record or access through an online portal
- ☐ Hard copy

This authorization shall be effective until (Check one):

- ☐ All past, present, and future periods, OR
- ☐ Date or event:_____

unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

_____ _____
Name of the Individual Giving this Authorization Date of birth

_____ _____
Signature of the Individual Giving this Authorization Date

Note: HIPAA Authority for Right of Access: 45 C.F.R. § 164.524