Triage Cancer Estate Planning Toolkit: Tennessee

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.

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

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)

1. You need to sign the will, in front of two witnesses who have watched you sign or authorize someone else to sign the will, and understand what they are signing.

2. Your will does not need to be notarized to be legal in Tennessee. However, you may 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, Tennessee 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 Tennessee:

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 it

If you make a holographic will, it does not need to be signed by witnesses. But, two witnesses will need to confirm that the will was written in your handwriting. Keep in mind that 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 Tennessee if made by someone "in immediate peril of death" (e.g., terminally ill), who dies as a result. This will can only be used to pass down assets worth less than $1000, unless you are an active military service. In that case, you can pass down assets worth up to $10,000. Oral wills should be declared in front of two disinterested witnesses (people who are not included in your will), written down within 30 days of your death, and submitted to probate court within 6 months of your death. These wills cannot override a written will. 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 Tennessee, a general power of attorney allows you to appoint someone to manage your finances, including assets like your property, taxes, and government benefits. This person can make all financial decisions for you, or you can limit their powers to specific areas, like filing taxes or banking. This document can either go into effect when you sign it, or if you become incapacitated. You must indicate if it is to take effect upon signing, or only if you become incapacitated, on the power of attorney form. After that point, this document will remain in effect until you die, unless you revoke your power of attorney.

Part III of this toolkit 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.

The **Tennessee Advance Directive for Health Care** includes five parts.

1. **Appointment of Health Care Agent:** You can choose someone to make any and all health care decisions for you, including decisions about life-prolonging care, if your doctor determines you can no longer make these decisions yourself for any reason. You can also choose an alternate person if the first person you appoint is not available.
2. **Wishes for Quality of Life and Treatment:** You can use this document to express your preferences for life-sustaining care in case you cannot speak for yourself because you are seriously ill or unconscious. This includes specific situations, including letting your surrogate make these decisions for you, administering or withholding life-prolonging procedures, artificially administered nutrition (food offered through surgically-placed tubes), and any other instructions you would like to include. You can also indicate your preferences for organ donation and burial wishes with this document.
3. **Other Instructions:** You can indicate other choices, such as about hospice care and burial arrangements.
4. **Organ Donation:** You can indicate your choices about organ donation.
5. **Execution:** You must sign your advance health care directive to make it valid. You can have your signature witnessed by a notary public, or by two adult witnesses. Your witnesses cannot be your agent, and one witness cannot be related to you by blood, marriage, or adoption, or included in your will.

Your advance health care directive goes into effect when your doctor determines you can no longer understand or make health care decisions.

You can change or revoke your advance health care directive at any time and in any manner (e.g. destroying the document or notifying your doctor). This decision takes effect when you tell your doctor or other health care professional. Your decision to revoke your agent's power takes effect when you notify them.

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

Part III of this toolkit includes a sample form.

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 Tennessee, 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 orders (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
- Medically assisted nutrition, or fluid and food 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.

Tennessee does not have a dedicated funeral designation form, but you can use your advance health care directive to express your burial wishes.

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.

Tennessee does not have a death with dignity law. But, you can indicate other decisions related to end-of-life care through 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.

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Part III: Your State's Estate Planning Forms

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

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Power of Attorney for Financial Affairs

TENNESSEE DURABLE POWER OF ATTORNEY

I, _____, the principal, of _____, State of _____, hereby designate _____, of _____, State of _____, my attorney-in-fact (hereinafter my "attorney-in-fact"), to act as initialed below, in my name, in my stead and for my benefit, hereby revoking any and all financial powers of attorney I may have executed in the past.

EFFECTIVE DATE

(Choose the applicable paragraph by placing your initials in the preceding space)

_____ - A. I grant my attorney-in-fact the powers set forth herein immediately upon the execution of this document. These powers shall not be affected by any subsequent disability or incapacity I may experience in the future.

or

_____ - B. I grant my attorney-in-fact the powers set forth herein only when it has been determined in writing, by my attending physician, that I am unable to properly handle my financial affairs.

POWERS OF ATTORNEY-IN-FACT

My attorney-in-fact shall exercise powers in my best interests and for my welfare, as a fiduciary. My attorney-in-fact shall have the following powers:

(Choose the applicable power(s) by placing your initials in the preceding space)

_____ **BANKING** - To receive and deposit funds in any financial institution, and to withdraw funds by check or otherwise to pay for goods, services, and any other personal and business expenses for my benefit. If necessary, to effect my attorney-in-fact's powers, my attorney-in-fact is authorized to execute any document required to be signed by such banking institution.

_____ **SAFE DEPOSIT BOX** - To have access at any time or times to any safe-deposit box rented by me or to which I may have access, wheresoever located, including drilling, if necessary, and to remove all or any part of the contents thereof, and to surrender or relinquish said safe-deposit box; and any institution in which any such safe-deposit box may be located shall not incur any liability to me or my estate as a result of permitting my attorney-in-fact to exercise this power.

_____ **LENDING OR BORROWING** - To make loans in my name; to borrow money in my name, individually or jointly with others; to give promissory notes or other obligations therefor; and to deposit or mortgage as collateral or for security for the payment thereof any or all of my securities, real estate, personal property, or other

property of whatever nature and wherever situated, held by me personally or in trust for my benefit.

_____ **GOVERNMENT BENEFITS** - To apply for and receive any government benefits for which I may be eligible or become eligible, including but not limited to, Social Security, Medicare and Medicaid.

_____ **RETIREMENT PLAN** - To contribute to, select payment option of, roll-over, and receive benefits of any retirement plan or IRA I may own, except my attorney-in-fact shall not have power to change the beneficiary of any of my retirement plans or IRAs.

_____ **TAXES** - To complete and sign any local, state and federal tax returns on my behalf, pay any taxes and assessments due and receive credits and refunds owed to me and to sign any tax agency documents necessary to effectuate these powers.

_____ **INSURANCE** - To purchase, pay premiums and make claims on life, health, automobile and homeowners' insurance on my behalf, except my attorney-in-fact shall not have the power to cash in or change the beneficiary of any life insurance policy.

_____ **REAL ESTATE** - To acquire, purchase, exchange, lease, grant options to sell, and sell and convey real property, or any interests therein, on such terms and conditions, including credit arrangements, as my attorney-in-fact shall deem proper; to execute, acknowledge and deliver, under seal or otherwise, any and all assignments, transfers, deeds, papers, documents or instruments which my attorney-in-fact shall deem necessary in connection therewith.

_____ **PERSONAL PROPERTY** - To acquire, purchase, exchange, lease, grant options to sell, and sell and convey personal property, or any interests therein, on such terms and conditions, including credit arrangements, as my attorney-in-fact shall deem proper; to execute, acknowledge and deliver, under seal or otherwise, any and all assignments, transfers, titles, papers, documents or instruments which my attorney-in-fact shall deem necessary in connection therewith; to purchase, sell or otherwise dispose of, assign, transfer and convey shares of stock, bonds, securities and other personal property now or hereafter belonging to me, whether standing in my name or otherwise, and wherever situated.

_____ **POWER TO MANAGE PROPERTY**- To maintain, repair, improve, invest, manage, insure, rent, lease, encumber, and in any manner deal with any real or personal property, tangible or intangible, or any interests therein, that I now own or may hereafter acquire, in my name and for my benefit, upon such terms and conditions as my attorney-in-fact shall deem proper.

_____ **GIFTS** - To make gifts, grants, or other transfers (including the forgiveness of indebtedness and the completion of any charitable pledges I may have made) without consideration, either outright or in trust to such person(s) (including my attorney-in-fact hereunder) or organizations as my attorney-in-fact shall select, including, without limitation, the following actions: (a) transfer by gift in advancement of a bequest or devise to beneficiaries under my will or in the absence of a will to my spouse and

descendants in whatever degree; and (b) release of any life interest, or waiver, renunciation, disclaimer, or declination of any gift to me by will, deed, or trust

_____ **LEGAL ADVICE AND PROCEEDINGS** - To obtain and pay for legal advice, to initiate or defend legal and administrative proceedings on my behalf, including actions against third parties who refuse, without cause, to honor this instrument.

SPECIAL INSTRUCTIONS: On the following lines are any special instructions limiting or extending the powers I give to my attorney-in-fact (Write “None” if no additional instructions are given):

_____
_____
_____
_____

AUTHORITY OF ATTORNEY-IN-FACT: Any party dealing with my attorney-in-fact hereunder may rely absolutely on the authority granted herein and need not look to the application of any proceeds nor the authority of my attorney-in-fact as to any action taken hereunder. In this regard, no person who may in good faith act in reliance upon the representations of my attorney-in-fact or the authority granted hereunder shall incur any liability to me or my estate as a result of such act. I hereby ratify and confirm whatever my attorney-in-fact shall lawfully do under this instrument. My attorney-in-fact is authorized as he or she deems necessary to bring an action in court so that this instrument shall be given the full power and effect that I intend on by executing it.

LIABILITY OF ATTORNEY-IN-FACT: My attorney-in-fact shall not incur any liability to me under this power except for a breach of fiduciary duty.

REIMBURSEMENT OF ATTORNEY-IN-FACT: My attorney-in-fact is entitled to reimbursement for reasonable expenses incurred in exercising powers hereunder, and to reasonable compensation for services provided as attorney-in-fact.

AMENDMENT AND REVOCATION: I can amend or revoke this power of attorney through a writing delivered to my attorney-in-fact. Any amendment or revocation is ineffective as to a third party until such third party has notice of such revocation or amendment.

STATE LAW: This Power of Attorney is governed by the laws of the State of Tennessee.

PHOTOCOPIES: Photocopies of this document can be relied upon as though they were originals.

IN WITNESS WHEREOF, I have on this ____ day of _____, 20____, executed this Financial Power of Attorney.

_____
Principal’s Signature

We, the witnesses, each do hereby declare in the presence of the principal that the principal signed and executed this instrument in the presence of each of us, that the principal signed it willingly, that each of us hereby signs this Power of Attorney as witness at the request of the principal and in the principal's presence, and that, to the best of our knowledge, the principal is eighteen years of age or over, of sound mind, and under no constraint or undue influence.

_____
Witness's Signature

_____
Address

_____
Witness's Signature

_____
Address

STATE OF _____

_____ County, ss.

On this ____ day of _____, 20____, before me appeared _____, as Principal of this Power of Attorney who proved to me through government issued photo identification to be the above-named person, in my presence executed foregoing instrument and acknowledged that (s)he executed the same as his/her free act and deed.

_____
Notary Public

My commission expires: _____

SPECIMEN SIGNATURE AND ACCEPTANCE OF APPOINTMENT

I, _____, the attorney-in-fact named above, hereby accept appointment as attorney-in-fact in accordance with the foregoing instrument.

_____
Attorney-in-Fact's Signature

STATE OF _____

_____ County, ss.

On this ____ day of _____, 20____, before me appeared _____, as Attorney-in-Fact of this Power of Attorney who proved to me through government issued photo identification to be the above-named person, in my presence executed the foregoing acceptance of appointment and acknowledged that (s)he executed the same as his/her free act and deed.

_____
Notary Public

My commission expires: _____

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Part III: Your State's Estate Planning Forms

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Advance Health Care Directive

ADVANCE DIRECTIVE FOR HEALTH CARE*
(Tennessee)

Instructions: Parts 1 and 2 may be used together or independently. Please mark out/void any unused part(s). Part 5, Block A or Block B must be completed for all uses.

I, _____, hereby give these advance instructions on how I want to be treated by my doctors and other health care providers when I can no longer make those treatment decisions myself.

Part 1

Agent: I want the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: _____ Relation: _____ Home Phone: _____ Work Phone: _____
Address: _____ Mobile Phone: _____ Other Phone: _____

Alternate Agent: If the person named above is unable or unwilling to make health care decisions for me, I appoint as alternate the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: _____ Relation: _____ Home Phone: _____ Work Phone: _____
Address: _____ Mobile Phone: _____ Other Phone: _____

My agent is also my personal representative for purposes of federal and state privacy laws, including HIPAA.

When Effective (mark one): ☐ I give my agent permission to make health care decisions for me at any time, even if I have capacity to make decisions for myself. ☐ I do not give such permission (this form applies only when I no longer have capacity).

Part 2

Indicate Your Wishes for Quality of Life: By marking "yes" below, I have indicated conditions I would be willing to live with if given adequate comfort care and pain management. By marking "**no**" below, I have indicated conditions I would not be willing to live with (that to me would create an **unacceptable** quality of life).

☐ Yes ☐ No	**Permanent Unconscious Condition:** I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
☐ Yes ☐ No	**Permanent Confusion:** I become unable to remember, understand, or make decisions. I do not recognize loved ones or cannot have a clear conversation with them.
☐ Yes ☐ No	**Dependent in all Activities of Daily Living:** I am no longer able to talk or communicate clearly or move by myself. I depend on others for feeding, bathing, dressing, and walking. Rehabilitation or any other restorative treatment will not help.
☐ Yes ☐ No	**End-Stage Illnesses:** I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that no longer responds to treatment; chronic and/or damaged heart and lungs, where oxygen is needed most of the time and activities are limited due to the feeling of suffocation.

Indicate Your Wishes for Treatment: If my quality of life becomes unacceptable to me (as indicated by one or more of the conditions marked "no" above) and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. By marking "yes" below, I have indicated treatment I want. By marking "**no**" below, I have indicated treatment I **do not want**.

☐ Yes ☐ No	**CPR (Cardiopulmonary Resuscitation):** To make the heart beat again and restore breathing after it has stopped. Usually this involves electric shock, chest compressions, and breathing assistance.
☐ Yes ☐ No	**Life Support / Other Artificial Support:** Continuous use of breathing machine, IV fluids, medications, and other equipment that helps the lungs, heart, kidneys, and other organs to continue to work.
☐ Yes ☐ No	**Treatment of New Conditions:** Use of surgery, blood transfusions, or antibiotics that will deal with a new condition but will not help the main illness.
☐ Yes ☐ No	**Tube feeding/IV fluids:** Use of tubes to deliver food and water to a patient's stomach or use of IV fluids into a vein, which would include artificially delivered nutrition and hydration.

PLEASE SIGN ON PAGE 2

Part 3 **Other instructions, such as hospice care, burial arrangements, etc.:** _____

_____

_____

_____

_____

(Attach additional pages if necessary)

Part 4 Organ donation: Upon my death, I wish to make the following anatomical gift for purposes of transplantation, research, and/or education (mark one):

☐ Any organ/tissue ☐ My entire body ☐ Only the following organs/tissues: _____

_____

☐ No organ/tissue donation

SIGNATURE

Part 5 Your signature must **either** be witnessed by two competent adults ("Block A") **or** by a notary public ("Block B").

Signature: _____ Date: _____
(Patient)

_____

Block A Neither witness may be the person you appointed as your agent or alternate, and at least one of the witnesses must be someone who is not related to you or entitled to any part of your estate.

Witnesses:

1. I am a competent adult who is not named as the agent. I witnessed the patient's signature on this form.

_____
Signature of witness number 1

2. I am a competent adult who is not named as the agent. I am not related to the patient by blood, marriage, or adoption and I would not be entitled to any portion of the patient's estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the patient's signature on this form.

_____
Signature of witness number 2

_____

Block B You may choose to have your signature witnessed by a notary public instead of the witnesses described in Block A.

STATE OF TENNESSEE
COUNTY OF _____

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person who signed as the "patient." The patient personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

My commission expires: _____ _____
Signature of Notary Public

WHAT TO DO WITH THIS ADVANCE DIRECTIVE: (1) provide a copy to your physician(s); (2) keep a copy in your personal files where it is accessible to others; (3) tell your closest relatives and friends what is in the document; (4) provide a copy to the person(s) you named as your health care agent.

* This form replaces the old forms for durable power of attorney for health care, living will, appointment of agent, and advance care plan, and eliminates the need for any of those documents.

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Part III: Your State's Estate Planning Forms

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Physician Orders for Life Sustaining Treatment (POLST)

Directions for Health Care Professionals

Completing POST

Must be completed by a health care professional based on patient preferences, patient best interest, and medical indications.

To be valid. POST must be signed by a physician or, at discharge or transfer from a hospital or long term care facility, by a nurse practitioner (NP), clinical nurse specialist (CNS), or physician assistant (PA). Verbal orders are acceptable with follow-up signature by physician in accordance with facility/community policy.

Person with DNR in effect at time of discharge must have POST completed by health care facility prior to discharge and copy of POST provided to qualified medical emergency personnel.

Photocopies/faxes of signed POST forms are legal and valid.

Using POST

Any incomplete section of POST implies full treatment for that section.

No defibrillator (including AEDs) should be used on a person who has chosen "Do Not Attempt Resuscitation".

Oral fluids and nutrition must always be offered if medically feasible.

When comfort cannot be achieved in the current setting, the person, including someone with "Comfort Measures Only", should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).

IV medication to enhance comfort may be appropriate for a person who has chosen "Comfort Measures Only".

Treatment of dehydration is a measure which prolongs life. A person who desires IV fluids should indicate "Limited Interventions" or "Full Treatment".

A person with capacity, or the Health Care Agent or Surrogate of a person without capacity, can request alternative treatment.

Reviewing POST

This POST should be reviewed if:

(1) The patient is transferred from one care setting or care level to another, or
(2) There is a substantial change in the patient's health status, or
(3) The patient's treatment preferences change.

Draw line through sections A through D and write "VOID" in large letters if POST is replaced or becomes invalid.

COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED.

A COPY OF THIS FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED

Tennessee Physician Orders for Scope of Treatment (POST, sometime called "POLST")

This is a Physician Order Sheet based on the medical conditions and wishes of the person identified at right ("patient"). Any section not completed indicates full treatment for that section. When need occurs, first follow these orders, then contact physician.

Patient's Last Name

First Name/Middle Initial

Date of Birth

Section A *Check One Box Only*

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

☐ **Resuscitate (CPR)** ☐ **Do Not Attempt Resuscitation (DNR / no CPR) (Allow Natural Death)**

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

Section B

Check One Box Only

MEDICAL INTERVENTIONS. Patient has pulse and/or is breathing.

☐ **Comfort Measures Only.** Relieve pain and suffering through the use of any medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. **Do not transfer to hospital for life-sustaining treatment. Transfer only if comfort needs cannot be met in current location. Treatment Plan: Maximize comfort through symptom management.**

☐ **Limited Additional Interventions.** In addition to care described in Comfort Measures Only above, use medical treatment, antibiotics, IV fluids and cardiac monitoring as indicated. No intubation, advanced airway interventions, or mechanical ventilation. May consider less invasive airway support (e.g. CPAP, BiPAP). **Transfer** to hospital if indicated. Generally avoid the intensive care unit. **Treatment Plan: basic medical treatment.**

☐ **Full Treatment.** In addition to care described in Comfort Measures Only and Limited Additional Interventions above, use intubation, advanced airway interventions, and mechanical ventilation as indicated. **Transfer** to hospital and/or intensive care unit if indicated. **Treatment Plan: Full treatment including in the intensive care unit.**

*Other Instructions:*_____

Section C

Check One

ARTIFICIALLY ADMINISTERED NUTRITION. Oral fluids & nutrition must be offered if feasible.

☐ No artificial nutrition by tube.
☐ Defined trial period of artificial nutrition by tube.
☐ Long-term artificial nutrition by tube.

*Other Instructions:*_____

Section D

Must be Completed

Discussed with:
☐ Patient/Resident
☐ Health care agent
☐ Court-appointed guardian
☐ Health care surrogate
☐ Parent of minor
☐ Other: _____(Specify)

The Basis for These Orders Is: (Must be completed)
☐ Patient's preferences
☐ Patient's best interest (patient lacks capacity or preferences unknown)
☐ Medical indications
☐ (Other) _____

Physician/NP/CNS/PA Name (Print)	**Physician/NP/CNS/PA Signature** **Date** NP/CNS/PA (Signature at Discharge)	**MD/NP/CNS/PA Phone Number:** ( )

Signature of Patient, Parent of Minor, or Guardian/Health Care Representative

Preferences have been expressed to a physician and /or health care professional. It can be reviewed and updated at any time if your preferences change. If you are unable to make your own health care decisions, the orders should reflect your preferences as best understood by your agent/surrogate.

Name (Print)	Signature	Relationship (write "self" if patient)

Agent/Surrogate	Relationship	Phone Number ( )

Health Care Professional Preparing Form	Preparer Title	Phone Number ( )	Date Prepared

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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