



## Triage Cancer Estate Planning Toolkit: Iowa

### 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.

Iowa probate courts accept typed and printed written wills. Handwritten wills are not valid in Iowa. To make a valid written will in Iowa:

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 at least 16 years of age, who are not included in your will. The witnesses must also sign the will with you and each other present. If a witness is included in your will, they will have to give up the difference between the value of what you left to them in the will and what they would have received through intestate succession (if you had died without a will).
3. Your will does not need to be notarized to be legal in Iowa. But you can make your will “self-proving,” or accepted in probate court without the court needing to contact your witnesses. To do this, sign an affidavit in front of a notary public.

Iowa allows you to execute your will remotely (e.g. sign an affidavit by teleconferencing with a notary). This change was made permanent in 2023 by the Iowa legislature in House File 397. 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.

#### 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.

An Iowa statutory form for power of attorney allows you to appoint someone to manage your finances for you, including your property, taxes, and government benefits. You can also appoint a successor agent or co-agent in the “special instructions” section. This person can make all financial decisions for you, or you can limit their powers to specific areas, like filing taxes or banking. You can also use this document to nominate a conservator in advance, in case a court decides one is necessary. Unless you indicate otherwise in the “special instructions” section, this document takes effect immediately after you sign it and will remain in effect until you die, unless you revoke your power of attorney.

Part III includes a sample form.

## **State Laws About Advance Directives for Health Care**

An advance health care directive (AHCD) 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 Iowa, this document contains two parts.

1. **Iowa Durable Power of Attorney for Health Care:** This document lets you choose someone (your “agent”) to make health care decisions for you, including decisions about life-sustaining care, any time your doctor determines that you cannot make them yourself. You can also appoint an alternate person to make these decisions if the first person you chose isn’t available. If there are directions you want your agent to follow, you can share those in the “other directions” section. You can also appoint someone to be in charge of the final disposition of your remains by including a “Declaration of Designee for Final Disposition” form.
2. **Iowa Declaration:** Also known as a “living will,” this document lets you express your preferences for having life-sustaining procedures withheld or withdrawn if you develop a terminal condition and can no longer make your own health care decisions. This document goes into effect if your doctor determines you have reached this state. In Iowa, this form allows you to:
  - Indicate if you would like life-sustaining procedures withdrawn, if there is no reason to believe they would lead to your recovery and they do not alleviate pain
  - Describe specific directions for your life-sustaining care, if any
  - Describe limitations or special wishes, if any

At the end of your AHCD, you can indicate if you would like to make an organ donation upon death.

To make your advance health care directive legal, you must sign and date it in front of a witness. You can have your AHCD witnessed in two ways:

1. Sign your directive in front of a notary public
2. Sign your directive in front of two witnesses. They must be over 18, and cannot be:
  - Your doctor or other treating health care provider, or their employee
  - Your agent
  - One of your witnesses cannot be related to you by blood, marriage, or adoption “within a third degree of consanguinity” (this excludes people like uncles, aunts, step nieces, and step great-grandchildren)

You can revoke your advance health care directive at any time in any way. This change becomes effective when you or someone else communicates this to your attending physician.

You can revoke the power of the person you appointed to make decisions about the disposition of your remains by writing a signed statement.

Part III of this toolkit includes a sample advance health care directive.

## **State Laws About POLST/MOLST**

A physician orders for life-sustaining treatment (POLST) is a medical order completed by a seriously ill person and signed by a physician. In Iowa, this form is called the Iowa Physician Orders for Scope of Treatment (IPOST). The IPOST does not replace an advance health care directive. You can complete an IPOST form with your doctor. In Iowa, 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 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.

You can find this form in Part III of this toolkit.

### **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.

Iowa does not have a funeral designation form, but Iowa law allows you to appoint someone to handle the disposal of your remains through a “Declaration of Designee for Final Disposition” form as part of 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.

Iowa does not have a death with dignity law. However, 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 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](https://www.cdc.gov/phlp/publications/topic/hipaa.html).



## Triage Cancer Estate Planning Toolkit: Iowa

### 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



## **Triage Cancer Estate Planning Toolkit**



### **Part III: Your State's Estate Planning Forms**



#### **Power of Attorney for Financial Affairs**

*Disclaimer: This toolkit is intended to provide general information on the topics presented. It is provided with the understanding that Triage Cancer is not engaged in rendering any legal, medical, or professional services by its publication or distribution. Although this content was reviewed by a professional, it should not be used as a substitute for professional services.*

# IOWA STATUTORY POWER OF ATTORNEY FORM

## 1. POWER OF ATTORNEY

This power of attorney authorizes another person (your agent) to make decisions concerning your property for you (the principal). Your agent will be able to make decisions and act with respect to your property (including but not limited to your money) whether or not you are able to act for yourself. The meaning of authority over subjects listed on this form is explained in the Iowa Uniform Power of Attorney Act, Iowa Code chapter 633B.

This power of attorney does not authorize the agent to make health care decisions for you.

You should select someone you trust to serve as your agent. Unless you specify otherwise, generally the agent's authority will continue until you die or revoke the power of attorney or the agent resigns or is unable to act for you.

Your agent is not entitled to compensation unless you state otherwise in the optional Special Instructions.

This form provides for designation of one agent. If you wish to name more than one agent, you may name a coagent in the optional Special Instructions. Coagents must act by majority rule unless you provide otherwise in the optional Special Instructions.

If your agent is unable or unwilling to act for you, your power of attorney will end unless you have named a successor agent. You may also name a second successor agent.

This power of attorney becomes effective immediately upon signature and acknowledgment unless you state otherwise in the optional Special Instructions.

If you have questions about this power of attorney or the authority you are granting to your agent, you should seek legal advice before signing this form.

## DESIGNATION OF AGENT

I \_\_\_\_\_ (name of principal) name the following person as my agent:

Name of Agent \_\_\_\_\_

Agent's Address \_\_\_\_\_

Agent's Telephone Number \_\_\_\_\_

### **DESIGNATION OF SUCCESSOR AGENT(S) (OPTIONAL)**

If my agent is unable or unwilling to act for me, I name as my successor agent:

Name of Successor Agent \_\_\_\_\_

Successor Agent's Address \_\_\_\_\_

Successor Agent's Telephone Number \_\_\_\_\_

If my successor agent is unable or unwilling to act for me, I name as my second successor agent:

Name of Second Successor Agent \_\_\_\_\_

Second Successor Agent's Address \_\_\_\_\_

Second Successor Agent's Telephone Number \_\_\_\_\_

### **GRANT OF GENERAL AUTHORITY**

I grant my agent and any successor agent general authority to act for me with respect to the following subjects as defined in the Iowa Uniform Power of Attorney Act, Iowa Code chapter 633B:

(Initial each subject you want to include in the agent's general authority. If you wish to grant general authority over all of the subjects you may initial "All Preceding Subjects" instead of initialing each subject.)

- \_\_\_ Real Property
- \_\_\_ Tangible Personal Property
- \_\_\_ Stocks and Bonds
- \_\_\_ Commodities and Options
- \_\_\_ Banks and Other Financial Institutions
- \_\_\_ Operation of Entity or Business
- \_\_\_ Insurance and Annuities
- \_\_\_ Estates, Trusts, and Other Beneficial Interests
- \_\_\_ Claims and Litigation
- \_\_\_ Personal and Family Maintenance
- \_\_\_ Benefits from Governmental Programs or Civil or Military Service
- \_\_\_ Retirement Plans
- \_\_\_ Taxes
- \_\_\_ All Preceding Subjects

### **GRANT OF SPECIFIC AUTHORITY (OPTIONAL)**

My agent shall not do any of the following specific acts for me unless I have initialed the specific authority listed below:

(Caution: Granting any of the following will give your agent the authority to take actions that could significantly reduce your property or change how your property is distributed at your death. Initial only the specific authority you WANT to give your agent.)

- \_\_\_ Amend, revoke, or terminate a revocable inter vivos trust, if authorized by the trust.
- \_\_\_ Agree to the amendment or termination of any other inter vivos trust.
- \_\_\_ Make a gift to an individual who is not an agent, subject to the limitations of the Iowa Uniform Power of Attorney Act, Iowa Code section 633B.217, and any special instructions in this power of attorney.

Make gifts, either direct or indirect, to my agent acting under this power of attorney as follows:

- \_\_\_ Any such gift must be approved in writing by \_\_\_\_\_; or
- \_\_\_ No third party approval is needed.
- \_\_\_ Authorize another person to exercise the authority granted under this power of attorney.
- \_\_\_ Waive the principal's right to be a beneficiary of a joint and survivor annuity, including a survivor benefit under a retirement plan.
- \_\_\_ Exercise fiduciary powers that the principal has authority to delegate.
- \_\_\_ Disclaim or refuse an interest in property, including a power of appointment.

#### **LIMITATION ON AGENT'S AUTHORITY**

An agent that is not my ancestor, spouse, or descendant shall not use my property to benefit the agent or a person to whom the agent owes an obligation of support unless I have included that authority in the optional Special Instructions.

#### **SPECIAL INSTRUCTIONS (OPTIONAL)**

You may give special instructions on the following lines:

---

---

---

---

---

---

---

---

---

---

\_\_\_\_\_ shall have the authority to request an accounting of any agent.

### **EFFECTIVE DATE**

This power of attorney is effective immediately upon signature and acknowledgment unless I have stated otherwise in the optional Special Instructions.

### **NOMINATION OF CONSERVATOR AND GUARDIAN (OPTIONAL)**

If it becomes necessary for a court to appoint a conservator of my estate or guardian of my person, I nominate the following person(s) for appointment:

Name of Nominee for Conservator of My Estate \_\_\_\_\_

Nominee's Address \_\_\_\_\_

Nominee's Telephone Number \_\_\_\_\_

Name of Nominee for Guardian of My Person \_\_\_\_\_

Nominee's Address \_\_\_\_\_

Nominee's Telephone Number \_\_\_\_\_

### **RELIANCE ON THIS POWER OF ATTORNEY**

Any person, including my agent, may rely upon the validity of this power of attorney or a copy of it unless that person knows it has terminated or is invalid.

### **SIGNATURE AND ACKNOWLEDGMENT**

\_\_\_\_\_  
Your Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Your Name Printed

\_\_\_\_\_  
Your Address

\_\_\_\_\_  
Your Telephone Number

State of \_\_\_\_\_

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

This document was acknowledged before me on \_\_\_\_\_ (date), by  
\_\_\_\_\_ (name of principal)

(Seal, if any)

\_\_\_\_\_  
Signature of Notary

My commission expires \_\_\_\_\_

This document prepared by

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

## 2. IMPORTANT INFORMATION FOR AGENT

### AGENT'S DUTIES

When you accept the authority granted under this power of attorney, a special legal relationship is created between the principal and you. This relationship imposes upon you legal duties that continue until you resign or the power of attorney is terminated or revoked. You must do all of the following:

Do what you know the principal reasonably expects you to do with the principal's property or, if you do not know the principal's expectations, act in the principal's best interest.

Act in good faith.

Do nothing beyond the authority granted in this power of attorney.

Disclose your identity as an agent whenever you act for the principal by writing or printing the name of the principal and signing your own name as agent in the following manner:

\_\_\_\_\_  
\_\_\_\_\_  
(principal's name) by  
(your signature) as Agent

Unless the Special Instructions in this power of attorney state otherwise, you must also do all of the following:

Act loyally for the principal's benefit.

Avoid conflicts that would impair your ability to act in the principal's best interest.

Act with care, competence, and diligence.

Keep a record of all receipts, disbursements, and transactions made on behalf of the principal.

Cooperate with any person that has authority to make health care decisions for the principal to do what you know the principal reasonably expects or, if you do not know the principal's expectations, to act in the principal's best interest.

Attempt to preserve the principal's estate plan if you know the plan and preserving the plan is consistent with the principal's best interest.

### **TERMINATION OF AGENT'S AUTHORITY**

You must stop acting on behalf of the principal if you learn of any event that terminates this power of attorney or your authority under this power of attorney. Events that terminate a power of attorney or your authority to act under a power of attorney include any of the following:

Death of the principal.

The principal's revocation of the power of attorney or your authority.

The occurrence of a termination event stated in the power of attorney.

The purpose of the power of attorney is fully accomplished.

If you are married to the principal, a legal action is filed with a court to end your marriage, or for your legal separation, unless the Special Instructions in this power of attorney state that such an action will not terminate your authority.

### **LIABILITY OF AGENT**

The meaning of the authority granted to you is defined in the Iowa Uniform Power of Attorney Act, Iowa Code chapter 633B. If you violate the Iowa Uniform Power of Attorney Act, Iowa Code chapter 633B, or act outside the authority granted, you may be liable for any damages caused by your violation.

If there is anything about this document or your duties that you do not understand, you should seek legal advice.



## **Triage Cancer Estate Planning Toolkit**



### **Part III: Your State's Estate Planning Forms**



#### **Advance Health Care Directive**

*Disclaimer: This toolkit is intended to provide general information on the topics presented. It is provided with the understanding that Triage Cancer is not engaged in rendering any legal, medical, or professional services by its publication or distribution. Although this content was reviewed by a professional, it should not be used as a substitute for professional services.*



The  
*Gift*  
of  
Peace  
of Mind

*For Yourself, For Your Family*

A Step-By-Step Guide to Preparing Advance Directive Documents

## ADVISORY COMMITTEE

The following individuals served on the Advisory Committee for this project. Their effort, expertise and experience added depth and accuracy to this publication, for which the Center is most grateful:

**CAROLYN S. ADAMS, M.P.A.,**

Iowa Department of Public Health

**DANIEL J. BALDI, D.O.,**

Iowa Osteopathic Medical Association

**DOUGLAS W. BRENTON, M.D.,**

Iowa Medical Society

**DEANNA CLINGAN-FISCHER, J.D.,**

Iowa Department on Aging  
and the Iowa State Bar Association

**REVEREND RANDY EHRHARDT,**

West Des Moines Christian Church

**KATHRYN FREILINGER**

Iowa Health System – Central Region

**KAREN HANSON, J.D.,**

Iowa Hospital Association

**LISA LACHER, M.A.,**

Drake University Department of Marketing  
and Communications

**MAUREEN MCGUIRE, J.D.,**

Office of the Attorney General

**TOM WESTBROOK, PH.D.,**

Drake University Adult Student Resource Center

## REFERENCES

### *Primary References:*

Emanuel LL, Emanuel EJ. "The Medical Directive: A New Comprehensive Advance Care Document," *Journal of the American Medical Association*, June 9, '89; 261:3290. Copyright 1990. It does not reflect the official policy of the American Medical Association.

Reprint permission from Drs. Linda L. and Ezekiel J. Emanuel.

"Taking Steps To Plan for Critical Health Care Decisions," Vermont Ethics Network.

### *Other References:*

Gillick MR, Hesse K, Mazzapica N., Medical Technology at the End of Life: What Would Physicians and Nurses Want for Themselves? *Archives of Internal Medicine*, 1993; 153:2542-2547

"Health Care Powers of Attorney," Commission on Legal Problems of the Elderly, American Bar Association.

"Planning for Incapacity: A Self-Help Guide," Legal Counsel for the Elderly, Sponsored by the American Association of Retired Persons.

## GRANT SUPPORT

This project was supported by a grant from the State of Iowa and administered by the Iowa Department of Public Health. Initial printing costs were supported by Iowa Health - Des Moines.

## HOW TO USE THIS BOOKLET

The purpose of this booklet is to educate the public about advance directives. By doing so, we hope to increase the use of advance directives, as well as the quality and accuracy of the documents themselves. The reader is led through a series of steps that ultimately lead to filling out the advance directive documents in an informed manner.

This booklet can be used in a variety of ways.

### *For example:*

- An individual, couple or family member can use it when planning for the future.
- A health educator or human resources director can use it in large group education programs.
- A physician, nurse or health care facility employee can use it when talking with patients or clients about future health decisions.

**You may make as many copies of the booklet itself, the advance directive forms and instructions, and the values survey as you need.**

The Living Will and Durable Power of Attorney for Health Care forms included in this booklet are meant to be duplicated and used by individuals. Duplicate copies are legal documents if properly witnessed or notarized. The values survey and medical situation worksheet are not legal documents themselves, but are intended for use in guiding decision making. For additional copies of this publication, call or write:

Iowa Department on Aging  
510 E. 12th Street, Suite 2  
Des Moines, Iowa 50319  
515-725-3333

You may also access a copy online by visiting:  
[www.aging.iowa.gov](http://www.aging.iowa.gov)

An effort has been made to answer as many questions as could be anticipated on the subject of advance directives. If questions remain, we urge you to discuss them with your health provider or your lawyer.

## INTRODUCTION

This educational booklet was produced by the Drake University Center for Health Issues, a multi-disciplinary organization dedicated to public education about economic and ethical issues in health care. It is about making health care decisions in advance and creating peace of mind for you and your family regarding these decisions.

If you suddenly became so ill that you were unable to make medical treatment decisions for yourself, the burden of deciding would fall to your family and loved ones. It is for them that you read this booklet and complete the enclosed advance directive documents.

Medical technology can extend life, but the quality of that life varies for each person. Decisions about what is tolerable in life and in the dying process are personal and should be made individually before the opportunity is lost.

Advance directives, such as the Living Will and the Durable Power of Attorney for Health Care have grown out of a desire to maintain individual control over one's life. These documents work by extending the right of self-determination into the future. By recording our choices now (as competent persons), we can influence healthcare decisions made for us in the future.

"The Gift of Peace of Mind: For Yourself, For Your Family" is intended for use by health providers when talking to patients about advance directives, as well as by lay persons who wish to complete advance directives as individuals or in group settings. It is a detailed guide to the steps involved in filling out advance directive documents. We encourage you to duplicate it for your use.

This booklet is intended for informational purposes only and is subject to revision if laws should change.

# TABLE OF CONTENTS

## STEP I: UNDERSTANDING

### ADVANCE DIRECTIVES ..... 1-3

What are advance directives? ..... 1

Can health care decisions be made for me without advance directives? ..... 1

Who can legally complete an advance directive? ..... 1

Which advance directive documents are legal and available in Iowa? ..... 1

Do I need to complete both documents? ..... 2

Where can I get a Living Will/Durable Power of Attorney for Health Care form? ..... 2

How do I complete advance directives? ..... 2

What should I do with the completed advance directives? ..... 2

What if I change my mind? ..... 2

What if a doctor is unwilling to comply with my Living Will or my agent's decisions? ..... 2

If I move to another state, will my advance directives be valid? ..... 3

If I am in an accident, how will the police and ambulance crews know about my advance directives? ... 3

Can I be required to sign these documents as a condition for admission to a health care facility? ..... 3

Do I need an attorney to complete an advance directive document? ..... 3

Who should be my agent? ..... 3

What if I don't have anyone to be my agent? ..... 3

## STEP II: UNDERSTANDING LEGAL

### AND MEDICAL TERMS ..... 4-5

## STEP III: VALUES SURVEY ..... 6

What do you value most about your life? ..... 6

What kinds of mental or physical conditions would make you think that treatments that prolong dying should no longer be used? ..... 6

How might your personal relationships and responsibilities affect your own medical decisions? .... 6

How do you feel about death and dying? ..... 6

## STEP IV: MEDICAL

### SITUATIONS WORKSHEETS ..... 7-10

## STEP V: COMPLETING

### THE DOCUMENTS ..... 11-17

Checklist for Completing the Living Will/ Durable Power of Attorney for Health Care ..... 11

Instructions for Completing the Living Will/ Durable Power of Attorney for Health Care ..... 12-13

Living Will/Durable Power of Attorney for Health Care form ..... 15-17

## STEP VI: ADDITIONAL

### INFORMATION ..... 19

Questions for an agent to ask the medical team ..... 19

Notes ..... 20

Wallet card ..... 21

## STEP I: UNDERSTANDING ADVANCE DIRECTIVES

### What are advance directives?

Advance directives are documents that enable you to make decisions now about your medical care in the future. They offer guidance to your family and doctors when you cannot speak for yourself, and help to assure that your values and important wishes are carried out. There are two advance directive documents recognized legally in Iowa. They are explained below.

### Can health care decisions be made for me without advance directives?

Yes. If you have not completed an advance directive and are unable to make decisions, family members will make health care decisions for you, after talking with your doctors about your condition. However, it is best that these people understand your wishes and values. Completing advance directive documents can give you greater assurance that your wishes will be carried out. They also can give your family members peace of mind that they are doing as you would prefer.

### Who can legally complete an advance directive?

Any competent adult (18 years or older) can complete an advance directive. A competent adult is one who has the capacity to understand the nature and possible results of his or her medical condition and to make independent decisions regarding treatment.

### Which advance directive documents are legal and available in Iowa?

Iowa law provides two types of advance directives—A Durable Power of Attorney for Health Care and a Living Will. However, these documents **can** be combined into one form, which is found on pages 15-17 of this book.

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

The Durable Power of Attorney for Health Care is a legal document that allows you to choose someone as your agent (someone who acts for you) to make health care decisions whenever you cannot, due to unconsciousness or loss of ability to think and reason. This agent is required to make decisions according to directions you provide in writing or verbally to him or her. If your wishes are not clearly understood and defined, then your agent will make decisions based on what he or she believes to be in your best interest. Your agent is given the right to examine your medical records.

The Durable Power of Attorney for Health Care must be filled out and witnessed while you are still capable of making decisions for yourself. Any incapacity you may suffer later in your life will then be covered by the Durable Power of Attorney for Health Care.

The Durable Power of Attorney for Health Care comes into play when your doctor has determined that you are unable to make health decisions for yourself, even when the situation is temporary, such as after a car accident or a severe, sudden illness. Unlike a Living Will, which is the second type of advance directive and is discussed below, the Durable Power of Attorney for Health Care is not restricted to patients with permanent unconsciousness, with a condition that will lead to their death (often called a terminal or fatal condition) or to decisions about procedures that delay the dying process (life-sustaining procedures).

#### **The following are tasks involved when filling out the Durable Power of Attorney for Health Care:**

- **Choosing an agent** (someone who acts for you) to make health care decisions for you whenever, in the judgment of your doctor, you are unable to make health care decisions because of loss of consciousness or loss of ability to think and reason. As long as you are able to make your own decisions you, not your agent, have the authority to make treatment decisions. Typically, an adult child, a spouse, or a friend is chosen as a health care agent.
- **Making decisions regarding specific health care treatments that you do or do not want in certain situations.**
- **Having the document witnessed or notarized.**
- **Distributing the Durable Power of Attorney for Health Care to the appropriate people.**

#### **THE LIVING WILL**

**(known in Iowa as *The Declaration Relating to Use of Life-Sustaining Procedures.*)**

A Living Will is a document directing your physician to withhold or withdraw certain treatments (life-sustaining procedures) that could prolong the dying process. This advance directive becomes effective only at a point when, in the written opinion of your doctor (confirmed by one other doctor), you are expected to die soon and you are unable to make health decisions for yourself (because you are unconscious or unable to think and reason) or you are determined to be

permanently unconscious (irreversible coma, persistent vegetative state).

### Do I need to complete both documents?

It is up to you. The combined form in this book includes both. If you would like to complete **just** the Living Will or Durable Power of Attorney for Health Care, consult your attorney.

The Living Will and the Durable Power of Attorney for Health Care are legal documents that, when considered together, provide a very clear picture of your wishes. Through a Durable Power of Attorney for Health Care, your agent can make all of your health care decisions, even those that would be covered by a Living Will. However, if you know you do not want to have your death prolonged by machines, drugs or treatments, you may also want to sign a Living Will since it provides information to your doctor if you don't have an agent or Durable Power of Attorney for Health Care or your agent is not available.

### Where can I get a Living Will/Durable Power of Attorney for Health Care form?

Forms and directions can be found on pages 11-17. You are welcome to copy these forms to use for yourself or to give to family and friends. For additional copies of this booklet, call or write:

Iowa Department on Aging  
510 E. 12th Street, Suite 2  
Des Moines, Iowa 50319  
515-725-3333

You may also access a copy online by visiting:  
[www.aging.iowa.gov](http://www.aging.iowa.gov)

### How do I complete advance directives?

As you read this booklet, you will find very detailed instructions on how to fill out the documents. After they are filled out, your signature must be witnessed or notarized or be legally recognized.

Legal requirements for witnessing are the same for both the Living Will and the Durable Power of Attorney for Health Care. Each form must be signed and dated and then, either two people over the age of 18 must witness your signature and sign on the lines labeled for witnesses, **or** you must get the form notarized. At least one of the witnesses **must not** be related to you by blood, marriage, or adoption. If you use a notary, witnesses are not necessary. The following persons **cannot** legally act as a witness for you:

- Someone who has been appointed as your agent on the Durable Power of Attorney for Health Care form

- Someone who is treating you as a patient, such as your doctor or nurse
- An employee of anyone treating you (including any employee of your doctor, the hospital, nursing home or hospice where you may obtain medical treatment), unless the employee is also your relative

### What should I do with the completed advance directives?

Copies must be made and given to family members, your health care agent, your family doctor and, if appropriate for you, your pastor, priest or rabbi. It is also important to remember that a copy should be taken to the hospital with you every time you are admitted, to ensure that hospital staff are aware of it.

It is important to communicate with your loved ones and doctors about the existence of your completed advance directives and about the information they contain. This will make your family, agent and doctors more certain of your wishes and more comfortable making decisions for you.

Your doctor or nurse can be a very valuable source of information when you have questions about certain medical treatments. They can help you understand what types of situations might arise and what your treatment options might be in such cases. Schedule a time to talk with him or her about these concerns.

### What if I change my mind?

You may change or cancel these documents at any time, regardless of your physical or mental condition. If changes are made in writing, you should put your initials and a date by each change, and sign and date it again at the bottom of the form. Copies of the changed advance directives should be made and distributed as before. If you wish to cancel the form, you must tell your doctor and it's also a good idea to destroy the document. Iowa law does not require you to cancel either document in writing. It can be done verbally.

Situations and values change as you age and it is important to re-evaluate your advance directives every year to ensure that they remain accurate.

### What if a doctor is unwilling to comply with my Living Will or my agent's decisions?

If, in the future, a doctor or administrator of a hospital or health care facility is unwilling to follow your wishes as recorded in your advance directive documents, or as made by your agent, the doctor or

transfer you to another doctor or facility that is willing to do so.

**If I move to another state, will my advance directive be valid?**

They should be honored in any state, as they are evidence of your wishes no matter where you are. However, the legal requirements for advance directive documents vary from state to state. If you want to be absolutely safe when you move to another state, it is a good idea to complete new documents that meet the legal requirements of that state. This is also true if you live in another state for a portion of the year.

**If I am in an accident, how will the police and ambulance crews know about my advance directives?**

In case you are involved in a car accident in Iowa, or another state, you should carry a wallet card that shows that you have signed an advance directive in Iowa and how to get in touch with your agent. This cannot guarantee that your wishes will be carried out, but will go far in letting others know of them. A wallet card is included on the inside back cover of this booklet.

**Can I be required to sign these documents as a condition for admission to a health care facility?**

No. A hospital or nursing home cannot refuse to admit you just because you have not signed a Living Will or Durable Power of Attorney for Health Care. If any health care facility tries to force you to sign an advance directive, you should contact:

Iowa Department of Inspections and Appeals  
Lucas State Office Building  
321 East 12th Street  
Des Moines, Iowa 50319-0083  
515-281-7102  
email: [webmaster@dia.iowa.gov](mailto:webmaster@dia.iowa.gov)

All such facilities are required by law, however, to ask you if you have an advance directive and to offer you information about them.

**Do I need an attorney to complete advance directives?**

No. An attorney is not necessary to legally complete these documents. However, it is important that they be completed correctly. Having an attorney involved may give you peace of mind. You also may wish to contact your attorney with any questions or concerns about the effect of these documents.

**Who should be my agent?**

The choice of your agent (known legally as the "attorney-in-fact") is one of the most important parts of completing a Durable Power of Attorney for Health Care. Your agent will have direct control over your health if you become unable to make health care decisions.

Therefore, it is necessary that your agent be someone you trust, and someone who is capable of understanding the responsibilities involved in being a health care agent. Many people choose a spouse or an adult child, but the agent does not have to be a member of your family. Some people choose a friend, spiritual leader or their personal attorney. Be certain to spend time with the person you appoint ensuring they understand in detail your values and specific medical treatment wishes. The values survey and medical situation worksheet included in this booklet can be very valuable tools when talking about these issues.

**In Iowa, the following persons cannot be appointed as an agent:**

- Someone who is treating you as a patient, such as your doctor or nurse
- An employee of anyone treating you (including any employee of your doctor, or the hospital, nursing home or hospice where you may obtain medical treatment), unless the employee also is your relative.

**What if I don't have anyone to be my agent?**

It may happen that you are unable to find an agent. Without an agent, you cannot execute a Durable Power of Attorney for Health Care. In that case, you should do the following:

- Complete just a Living Will by consulting your attorney.
- Review the values survey and complete the medical situations worksheet.
- Be sure to talk to your doctor and give him/her a copy of the Living Will. Give copies to family members. Also, take copies of all of these with you each time you are admitted to the hospital.

## STEP II

# UNDERSTANDING LEGAL AND MEDICAL TERMS

The following glossary of medical and legal terms, while accurate, is explanatory in nature and should not be considered as legal definitions. For further information, contact your physician or attorney.

### **Advance Directive –**

A general term for legal documents (such as a Living Will or a Durable Power of Attorney for Health Care) that state a person's wishes for medical treatments in case he or she is not able to make his or her own decisions.

### **Agent –**

Someone who acts for you; the same as "attorney-in-fact."

### **Antibiotics –**

Drugs given to fight infection. The most common types of life-threatening infections in critically ill patients include pneumonia and urinary tract infections (kidney or bladder).

### **Artificial Provision of Nutrition and Fluids ("Tube Feeding") –**

Used either temporarily or permanently to feed patients when they are unable to swallow. There are three ways to feed patients artificially:

- A tube inserted through the nose and down to the stomach (nasogastric tube)
- A tube inserted through the stomach wall with surgery (gastrostomy tube)
- Tubes placed into veins in the arms or the chest (intravenous tubes or IVs)

**Iowa law permits persons to refuse tube feeding, just as they may refuse other medical treatments.**

### **Cardiopulmonary Resuscitation (CPR) –**

The procedure used when someone whose heart and/or breathing have stopped is brought back with the following actions:

- Pressing on the chest to squeeze the heart so that blood begins to circulate again
- Mechanical breathing (or other artificial breathing with a mouthpiece or tube and a bag) to push air into the lungs
- Electrical shocks to the chest to start the heart beating again (defibrillation)
- Medications given through a vein or directly into the heart

**The best results from CPR occur in a generally healthy person whose heart stops suddenly. If CPR is started quickly, it can save a person's life and prevent damage to the body's tissues and organs. On the other hand, permanent brain damage is common if more than about 4 minutes have gone by before CPR is started.**

### **Coma –**

A sleep-like (eyes closed) condition resulting from damage to the brain from an accident or a disease. A coma can be temporary (with either complete or partial recovery) or permanent.

### **Comfort Care –**

Care to keep someone as comfortable as possible, including pain medication, lip ointment and ice chips, turning and positioning of the body frequently (or using special mattresses) to prevent bed sores, and bathing. This type of care eases the dying process but does not stop it.

### **Competent –**

A competent person is one who has the capacity to understand the nature and possible results of his or her medical condition and to make their own decisions regarding treatment.

### **Declarant –**

A person who is making a statement about their wishes, or a declaration, in a legal document.

### **Do-Not-Resuscitate (DNR) –**

A DNR order is not the same thing as having an advance directive. If you want to avoid CPR, your doctor must write a separate order on your chart for each admission.

**Hospitals and some nursing homes will automatically attempt CPR (see definition) on anyone whose heart and/or breathing stops, unless there is a "Do-Not-Resuscitate" or "DNR" order on file for the patient. A DNR order (also called a "no code") can be written by a doctor with permission of the patient, his or her health care agent, or the family.**

### **Durable Power of Attorney for Health Care –**

A document that allows you to appoint another person (called your agent or attorney-in-fact) to make medical care decisions for you if you are unable to make your own decisions. There is a copy of one that is legal in Iowa, along with directions for filling it out, on pages 11-17.

### **Execute –**

To follow the guidelines set down in law for completing a document so that it is legal and enforceable. This may include having witnesses attest to your signing of the document.

### **Fatal (Terminal) Condition –**

See "terminal condition".

### **Informed Consent –**

Agreeing to a plan of treatment after you or your agent have been given information about your medical condition and the treatment options.

### **Life-Sustaining Procedures –**

Drugs, medical equipment, or treatments that can keep people alive who would otherwise die within a short, although uncertain, length of time.

### **Living Will –**

A document, known in Iowa as the Declaration Relating to Use of Life-Sustaining Procedures, that gives your attending physician direction to withhold or withdraw procedures that merely prolong the dying process and are not necessary for comfort or freedom from pain. There is a copy of one that is legal in Iowa, along with directions for filling it out, on pages 11-17.

### **Mechanical Breathing –**

Breathing by a machine (ventilator or respirator) when a patient is unable to do so for themselves. This is done by inserting a tube into the windpipe through the nose or mouth (endotracheal tube), or through a hole cut in the windpipe at the front of the neck (tracheostomy). The endotracheal tube is the more uncomfortable because it prevents the patient from talking and eating, and causes a gag reflex. The tracheostomy requires surgery, but can allow the patient to eat and talk when they are off the respirator for short periods of time. This type of machine is very useful for emergency situations.

### **Medical Technology –**

The equipment and treatments doctors use to diagnose and fight disease, treat injuries or maintain a patient's mental or physical condition. Some examples are surgery, CAT scans and other x-ray procedures, drugs and heart bypass machines.

### **Out-of-Hospital Do-Not-Resuscitate (DNR) –**

In 2002, a law passed which allows terminally ill adults to make non-resuscitation decisions in out-of-hospital settings. Previous to this law, terminally ill patients outside a hospital setting, could not be certain their end-of-life decision to not be resuscitated would be honored because there were no uniform guidelines for Emergency Medical Services (EMS) and other providers to follow. The Out of Hospital Do-Not Resuscitate (OOH DNR) law directs EMS providers and other health care providers not to perform unwanted resuscitation.

The law allows terminally ill patients to have their physicians prepare and sign an "Out of Hospital Do-Not-Resuscitate: (OOH DNR) order." The OOH DNR order is a

physician's order authorizing health care providers to allow a patient's wishes not to be resuscitated in an outside the hospital setting. The out-of-hospital setting may include a health care facility, a hospice setting or the patient's own home. Resuscitation is any medical intervention that utilizes mechanical or artificial means to sustain, restore, or supplant a spontaneous vital function, including but not limited to chest compression, defibrillation, intubation, and emergency drugs intended to alter cardiac function or otherwise sustain life. Patients will still receive comfort care, including pain medication.

The law also recognizes uniform OOH DNR identifiers such as a standard necklace or bracelet obtained through Medic Alert.

For more information on OOH DNR contact the Iowa Department of Public Health, Bureau of Emergency Management Services (EMS) at 1-800-728-3367 or [www.idph.state.ia.us/ems](http://www.idph.state.ia.us/ems)

### **Pain Medication –**

Medications that relieve pain resulting from injury or disease. They are a very important part of comfort care (see definition). These medications may have adverse side effects. They may also interfere with breathing in very ill patients. These side effects can indirectly shorten life.

### **Persistent Vegetative State (PVS) –**

A state of permanent unconsciousness that is not curable. It may take up to three months to be certain of a diagnosis of PVS. In patients with PVS, the centers in the brain that control thinking, speaking, hunger and thirst have been destroyed. PVS patients still have reflexes, such as aimless eye and muscle movements, yawning, coughing, and responses to touch or sound. Current medical knowledge indicates that they do not feel pain. This diagnosis includes patients who appear to be awake at times, but does not include those who are in a deeper coma with their eyes closed.

### **Principal –**

The person who is giving power to make health care decisions to a health care agent in the Durable Power of Attorney for Health Care document.

### **Terminal (Fatal) Condition –**

Iowa law defines a terminal condition as one that is incurable or irreversible, that without the administration of life-sustaining procedures, will, in the opinion of the attending physician (with confirmation by a second physician), result in death within a relatively short period of time. There is no specific time period identified. A terminal condition also can be a state of permanent unconsciousness from which, to a reasonable degree of medical certainty, there can be no recovery.

## STEP III VALUES SURVEY

The following questions can help you assess your values concerning medical and end-of-life decisions. You may use these questions to discuss your views with your agent, doctor and family. Talking with them about these values will give them peace of mind when the time arrives for difficult decisions to be made, and will help you make specific choices about medical procedures.

### **What do you value most about your life?**

#### **What brings you joy?**

##### *For example:*

- Living as long as possible
- Living an active life
- Enjoying the company of family and friends
- Remaining independent and in control

If you find that activity, independence, and/or social interaction are more valuable to you than merely living a long life, then making specific choices concerning medical situations (such as is found in the next section) will be particularly important to you and your family.

### **Are there certain mental or physical conditions that would make you think that treatments that prolong dying should no longer be used?**

##### *For example:*

- Lack of awareness of self or surroundings
- Inability to appreciate and continue the important relationships in your life
- Inability to think well enough to make every-day decisions
- Severe pain or discomfort
- Physical damage (such as paralyzed or amputated legs/arms)

It is important to consider some of the possible effects other than death that a severe illness or accident could cause.

### **How might your personal relationships and responsibilities affect your own medical decision making?**

##### *For example:*

- The desire to make your own decisions
- The desire to avoid burdening your family with difficult decisions
- Wanting to leave your family with good memories
- Avoiding using up your family savings

Providing your loved ones and caregivers with the information they need to make medical decisions for you is a wonderful gift. It can spare them great anguish, emotional stress and conflict. Even though losing you will be difficult for your family, knowing that they are doing the things you would have wanted will smooth the way.

### **How do you feel about death and dying?**

##### *For example:*

- You fear that death will be too prolonged, or that you will be in too much pain.
- You lost someone close to you and you do not want to die that way yourself.
- You want to die with respect and control, and in a setting that you choose as best for you and your family.
- You do not want to suffer for a long time.

All of these questions are very important to consider, along with decisions about medical treatments.

## STEP IV MEDICAL SITUATION WORKSHEETS

The following worksheets present four medical situations in which advance directives often are needed. After the description of each situation you will find a checklist of six possible treatments or procedures commonly used by doctors and nurses in hospitals to treat the condition described. Please read each situation carefully, try to imagine yourself in the situation, and decide whether you want, do not want, can't decide, or prefer that the treatment be tried first to determine if it would help you. Put a check mark in one column by each numbered treatment.

This worksheet is not a legal document. It is meant to be a guide for you, as well as for your family, agent, and doctor, not a complete list of all possible medical conditions.

Knowing your wishes in these particular situations, however, will offer guidance in other situations. We recommend that you fill out these worksheets and use this information to fill in Section 2 on the Durable Power of Attorney for Health Care form, and Section 4 on the Living Will form. This information will provide valuable assistance and direction to your agent and doctors in the future.

This section was adapted from Emanuel LL, Emanuel EJ, "The Medical Directive: A New Comprehensive Advance Care Document," *Journal of the American Medical Association*, June 9, '89; 261:3290. Copyright 1990.

**SITUATION 1** If my doctor has definitely determined that I have a condition that will shortly cause my death (fatal or terminal condition), and I am unconscious or otherwise unable to speak for myself, then my wishes regarding the use of the following would be:

|                                                                                                                                                                          | I WANT | I DO NOT WANT | I AM UNDECIDED | I WANT TO TRY:<br><i>If No Clear Improvement,<br/>Stop Treatment</i> |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|---------------|----------------|----------------------------------------------------------------------|
| <b>1. CARDIOPULMONARY RESUSCITATION (CPR)</b><br>The use of drugs, artificial breathing, external chest compression, and/or electric shock to restart the heart beating. |        |               |                |                                                                      |
| <b>2. MECHANICAL BREATHING</b><br>Breathing by a machine through a tube inserted through the mouth or nose.                                                              |        |               |                |                                                                      |
| <b>3. ARTIFICIAL NUTRITION/ HYDRATION</b><br>Feedings and fluid given through a tube in the veins, nose, or stomach.                                                     |        |               |                |                                                                      |
| <b>4. PAIN MEDICATIONS</b><br>(even if they dull consciousness and indirectly shorten my life).                                                                          |        |               |                |                                                                      |
| <b>5. ANTIBIOTICS</b><br>Drugs to fight infection.                                                                                                                       |        |               |                |                                                                      |
| <b>6. BLOOD OR BLOOD PRODUCTS</b>                                                                                                                                        |        |               |                |                                                                      |

**SITUATION 2** If I am unconscious from an accident or severe illness, and there is no known hope of recovering conscious awareness of my environment (irreversible coma or brain death), but machines and drugs could keep my body alive for years, then my wishes regarding the use of the following would be:

|                                                                                                                                                                          | I WANT | I DO NOT WANT | I AM UNDECIDED | I WANT TO TRY:<br><i>If No Clear Improvement,<br/>Stop Treatment</i> |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|---------------|----------------|----------------------------------------------------------------------|
| <b>1. CARDIOPULMONARY RESUSCITATION (CPR)</b><br>The use of drugs, artificial breathing, external chest compression, and/or electric shock to restart the heart beating. |        |               |                |                                                                      |
| <b>2. MECHANICAL BREATHING</b><br>Breathing by a machine through a tube inserted through the mouth or nose.                                                              |        |               |                |                                                                      |
| <b>3. ARTIFICIAL NUTRITION/ HYDRATION</b><br>Feedings and fluid given through a tube in the veins, nose, or stomach.                                                     |        |               |                |                                                                      |
| <b>4. PAIN MEDICATIONS</b><br>(even if they dull consciousness and indirectly shorten my life).                                                                          |        |               |                |                                                                      |
| <b>5. ANTIBIOTICS</b><br>Drugs to fight infection.                                                                                                                       |        |               |                |                                                                      |
| <b>6. BLOOD OR BLOOD PRODUCTS</b>                                                                                                                                        |        |               |                |                                                                      |

**SITUATION 3** If I become permanently confused or have declined mentally so that I am not capable of caring for myself or being part of any meaningful interaction with family and friends (such as Alzheimer's Disease, multiple strokes, or dementia), and I become ill, then my wishes regarding the use of the following would be:

|                                                                                                                                                                          | I WANT | I DO NOT WANT | I AM UNDECIDED | I WANT TO TRY:<br><i>If No Clear Improvement,<br/>Stop Treatment</i> |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|---------------|----------------|----------------------------------------------------------------------|
| <b>1. CARDIOPULMONARY RESUSCITATION (CPR)</b><br>The use of drugs, artificial breathing, external chest compression, and/or electric shock to restart the heart beating. |        |               |                |                                                                      |
| <b>2. MECHANICAL BREATHING</b><br>Breathing by a machine through a tube inserted through the mouth or nose.                                                              |        |               |                |                                                                      |
| <b>3. ARTIFICIAL NUTRITION/ HYDRATION</b><br>Feedings and fluid given through a tube in the veins, nose, or stomach.                                                     |        |               |                |                                                                      |
| <b>4. PAIN MEDICATIONS</b><br>(even if they dull consciousness and indirectly shorten my life).                                                                          |        |               |                |                                                                      |
| <b>5. ANTIBIOTICS</b><br>Drugs to fight infection.                                                                                                                       |        |               |                |                                                                      |
| <b>6. BLOOD OR BLOOD PRODUCTS</b>                                                                                                                                        |        |               |                |                                                                      |

**SITUATION 4** If I am healthy and am in an accident or suffer a sudden illness making me unable to make my wishes known, and my condition is potentially reversible in the opinion of my doctor, then my wishes regarding the use of the following would be:

|                                                                                                                                                                          | I WANT | I DO NOT WANT | I AM UNDECIDED | I WANT TO TRY:<br><i>If No Clear Improvement,<br/>Stop Treatment</i> |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|---------------|----------------|----------------------------------------------------------------------|
| <b>1. CARDIOPULMONARY RESUSCITATION (CPR)</b><br>The use of drugs, artificial breathing, external chest compression, and/or electric shock to restart the heart beating. |        |               |                |                                                                      |
| <b>2. MECHANICAL BREATHING</b><br>Breathing by a machine through a tube inserted through the mouth or nose.                                                              |        |               |                |                                                                      |
| <b>3. ARTIFICIAL NUTRITION/ HYDRATION</b><br>Feedings and fluid given through a tube in the veins, nose, or stomach.                                                     |        |               |                |                                                                      |
| <b>4. PAIN MEDICATIONS</b><br>(even if they dull consciousness and indirectly shorten my life).                                                                          |        |               |                |                                                                      |
| <b>5. ANTIBIOTICS</b><br>Drugs to fight infection.                                                                                                                       |        |               |                |                                                                      |
| <b>6. BLOOD OR BLOOD PRODUCTS</b>                                                                                                                                        |        |               |                |                                                                      |

## **STEP V**

### **COMPLETING THE DOCUMENTS**

#### **CHECKLIST FOR COMPLETING THE LIVING WILL/DURABLE POWER OF ATTORNEY FOR HEALTH CARE**

- ☐ **1. REVIEW THE VALUES SURVEY** on page 6 of this booklet.
- ☐ **2. COMPLETE THE MEDICAL SITUATION WORKSHEETS, IF DESIRED,** on pages 7-10 in this booklet.
- ☐ **3. CHOOSE AN AGENT,** and an alternate agent (if possible).

Choosing an agent is very important because it is the agent's job to make sure your health care wishes (as written in your Durable Power of Attorney for Health Care and spoken verbally) are carried out. You will be trusting this person to talk to the doctors, to think about the choices available, and to make decisions that are as close as possible to those you would make yourself.

Many people choose an adult child, a spouse, or another close relative, while others prefer a close friend. Regardless of your choice, your agent should be someone you trust, who knows you well, and who understands your values and beliefs. See page 3 for a list of those who cannot legally be your agent.

- ☐ **4. TALK TO YOUR AGENT.**

Talk to your agent about your beliefs and values as they relate to illness and death. It would be very beneficial for you to go over the values survey and medical situation worksheet from this booklet with your agent; these worksheets may help you express your thoughts more clearly. Make sure your agent understands your wishes.

- ☐ **5. TALK TO OTHERS.**

Ask your doctor or nurse for any medical information that you may need, find out if he or she supports your decision to complete an advance directive, and review your specific decisions in the medical situations with him or her. Talk with your family. You might also want to talk with your pastor, priest or rabbi for guidance and support.

- ☐ **6. COMPLETE THE FORM** found on pages 15-17 of this booklet by following the instructions.

- ☐ **7. SIGN THE DOCUMENT, AND HAVE IT WITNESSED OR NOTARIZED.**

- ☐ **8. MAKE COPIES.**

Make a copy for yourself, and one each for your alternate agent, your doctor, your hospital, and your pastor, priest or rabbi. Make sure each of these people receives a copy. You might also want to supply copies to your family and lawyer. There is space on the form to note where additional copies can be located.

- ☐ **9. GIVE THE ORIGINAL TO YOUR AGENT.**

## **INSTRUCTIONS FOR COMPLETING**

### **THE LIVING WILL/DURABLE POWER OF ATTORNEY FOR HEALTH CARE**

*Please refer to the document starting on page 15 and fill it out as you read these instructions carefully.*

#### **SECTION I** (The Living Will):

*The Declaration Relating to the Use of Life-Sustaining Procedures* is the legal name given to the Living Will in Iowa.

This statement says that if you are found to have a condition that will cause your death, you do not want your life lengthened by machines, drugs or other treatments. In Iowa law, two doctors must have examined you and certified in writing that you have a condition that will shortly result in death or permanent unconsciousness.

This statement also says that if you have a condition that will cause you to die soon, and you are also unable to make your own decisions due to unconsciousness or loss of ability to think and reason, you give your doctor permission to withhold (not start) or withdraw (stop) treatments that will only prolong dying. It is also clear in this statement that any treatments that make you more comfortable should not be stopped or avoided.

- a. The Living Will you just signed does not take effect unless you have been diagnosed with a condition that will result in your death, or are in an irreversible coma and you are not capable of making decisions.
- b. Pain medications and feeding by mouth are not included in the definition of "life-sustaining" procedures (treatments that lengthen the process of dying), and therefore will still be given unless you write otherwise.
- c. It is **your responsibility** to make sure that your physician and hospital have a copy of your Living Will.
- d. You can cancel this Living Will at any time by telling (in any way that you can) your doctor or agent that it is no longer in effect, no matter what your condition.

## **SECTION II (Durable Power of Attorney For Health Care):**

- ☐ **Neatly print or type the name (first, middle initial, last) of your agent on the lines provided. An "attorney-in-fact" is the legal name for your agent.**

The section following the name and address of your agent legally identifies what duties and responsibilities are involved in being a health care agent including:

- a. the power to make health care decisions for you only if a doctor says you are unable to make them yourself
- b. the fact that those decisions must be consistent with your desires
- c. the power to consent to the withholding or withdrawing of medical treatments, even if they are necessary to keep you alive
- d. the power to make these decisions for you for any physical or mental condition as long as they are consistent with verbal or written instructions. Your agent is also given the right to examine your medical records.

- ☐ **Neatly type or print the name, address, and phone number of an alternate agent who will serve if your agent is unable to do so. This is suggested but not required.**
- ☐ **There is a blank area provided for you to write in specific instructions, such as the specific medical treatments that you wish to avoid and in which situations. Use your medical worksheets as a guide.**
- ☐ **Sign your name as you do for any legal document, then neatly type or print your name (as principal, or the person granting the power of attorney or declarant person signing a Living Will) and address on the lines provided under you signature. Your signature must be made in the presence of your witnesses or a notary public.**
- ☐ **You have the option of using a notary, or having two witnesses sign your document. A notary public must observe you signing the document. Likewise, the two witnesses must see you sign and watch each other sign. Make sure that not more than one of your witnesses is related to you. Your doctor or an employee of your doctor cannot be a witness, unless they are also your relative. Also, your agent cannot be a witness.**
- ☐ **Sign your name as Grantor and date the page entitled "Authorization for Release of Protected Health Information to Nominated Health Care Attorney-in-Fact." This allows your proposed agent to obtain necessary medical records when an event occurs to invoke the Durable Power of Attorney for Health Care.**
- ☐ **Record the location of each copy of the Durable Power of Attorney for Health Care and Living Will.**



**DECLARATION RELATING TO LIFE-SUSTAINING PROCEDURES**  
(Living Will)  
**AND**  
**DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS**  
(Medical Power of Attorney)

**I. DECLARATION RELATING TO LIFE-SUSTAINING PROCEDURES**

If I should have an incurable or irreversible condition that will result either in death within a relatively short period of time or a state of permanent unconsciousness from which, to a reasonable degree of medical certainty, there can be no recovery, it is my desire that my life not be prolonged by the administration of life-sustaining procedures. If I am unable to participate in my health care decisions, I direct my attending physician to withhold or withdraw life-sustaining procedures that merely prolong the dying process and are not necessary to my comfort or freedom from pain.

This declaration is subject to any specific instructions or statement of desires I have added in "Additional Provisions" below.

**II. POWER OF ATTORNEY FOR HEALTH CARE DECISIONS**

I, \_\_\_\_\_, born \_\_\_\_\_, designate

(Type or Print) Name of Agent, Street Address, City, State, Zip Code and Phone Number

as my attorney in fact (my agent) and give to my agent the power to make health care decisions for me. This power exists only when I am unable, in the judgment of my attending physician, to make those health care decisions. The attorney in fact must act consistently with my desires as stated in this document or otherwise made known.

Except as otherwise specified in this document, this document gives my agent the power, where otherwise consistent with the laws of the State of Iowa, to consent to my physician not giving health care or stopping health care which is necessary to keep me alive.

This document gives my agent power to make health care decisions on my behalf, including to consent, to refuse to consent, or to withdraw consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition. This power is subject to any statement of my desires and any limitations included in this document.

I hereby revoke all prior Durable Powers Of Attorney for Health Care Decision.

OPTIONAL: If the person designated as agent above is unable to serve, I designate the following person to serve instead:

(Type or Print) Name of Alternate, Street Address, City, State, Zip Code and Phone Number

OPTIONAL: ADDITIONAL PROVISIONS - Insert specific instructions or statement of desires (if any):

YES\_\_ NO\_\_ In the event that medical professionals determine that I may be an organ donor, I agree to the use of life-sustaining procedures, including a ventilator, for the sole purpose and time period required to complete the organ donation. Nothing in this paragraph shall be construed to expand or detract from the laws related to anatomical gifts as outlined in the Iowa Code, Chapter 142C. The purpose of this paragraph is to practically and medically make organ donation possible.

Signed this \_\_\_\_ day of \_\_\_\_\_, \_\_\_\_.

\_\_\_\_\_  
Your Signature (Declarant/Principal)

\_\_\_\_\_  
Address, Street, City, State and Zip

\_\_\_\_\_  
Type or Print Your Name

**IMPORTANT NOTE: THIS DOCUMENT MUST BE SIGNED BEFORE A NOTARY PUBLIC OR TWO WITNESSES. SEE REVERSE FOR NOTARY OR WITNESS FORMS. IF YOU WANT TO EXECUTE EITHER A LIVING WILL DECLARATION OR A MEDICAL POWER OF ATTORNEY, BUT NOT BOTH, SEPARATE FORMS ARE AVAILABLE FROM THE IOWA STATE BAR ASSOCIATION. IF YOU HAVE QUESTIONS REGARDING THIS FORM OR NEED ASSISTANCE TO COMPLETE IT, YOU SHOULD CONSULT AN ATTORNEY.**

## NOTARY PUBLIC FORM

STATE OF \_\_\_\_\_, COUNTY OF \_\_\_\_\_ ss:

This document was acknowledged before me on \_\_\_\_\_, by \_\_\_\_\_.

\_\_\_\_\_, Notary Public

### WITNESS FORM

We, the undersigned, hereby state that we signed this document in the presence of each other and the Declarant/Principal and we witnessed the signing of the document by the Declarant/Principal or by another person acting on behalf of the Declarant/Principal at the direction of the Declarant/Principal; that neither of us is appointed as attorney in fact by this document; that neither of us are health care providers who are presently treating the Declarant/Principal, or employees of such a health care provider. We further state that we are both at least 18 years of age, and that at least one of us is not related to the Declarant/Principal by blood, marriage or adoption.

\_\_\_\_\_  
Signature of First Witness

\_\_\_\_\_  
Signature of Second Witness

\_\_\_\_\_  
Type or Print Name of Witness

\_\_\_\_\_  
Type or Print Name of Witness

\_\_\_\_\_  
Street Address, City, State and Zip Code

\_\_\_\_\_  
Street Address, City, State and Zip Code

### GENERAL INFORMATION REGARDING THIS DOCUMENT

1. "Health care" means any care, treatment, service, or procedure to maintain, diagnose, or treat an individual's physical or mental condition. "Life-sustaining procedure" means any medical procedure, treatment, or intervention which utilizes mechanical or artificial means to sustain, restore, or supplement a spontaneous vital function, and when applied to a person in a terminal condition, would serve only to prolong the dying process. "Life sustaining procedure" does not include administration of medication or performance of any medical procedure deemed necessary to provide comfort care or to alleviate pain.

2. The terms "health care" and "life-sustaining procedure" include nutrition and hydration (food and water) only when provided parenterally or through intubation (intravenously or by feeding tube). Thus, this document authorizes withholding nutrition or hydration that is provided intravenously or by feeding tube. If this is not what you want, you should set forth your specific instructions in the space provided on page 1.

3. The following individuals shall not be designated as the attorney in fact to make health care decisions under a durable power of attorney for health care:

- a. A health care provider attending the principal on the date of execution.
- b. An employee of such a health care provider unless the individual to be designated is related to the principal by blood, marriage, or adoption within the third degree of consanguinity.

4. The power of attorney for health care decisions or the declaration relating to use of life-sustaining procedures may be revoked at any time and in any manner by which the principal/declarant is able to communicate the intent to revoke, without regard to mental or physical condition. A revocation is only effective as to the attending health care provider upon its communication to the provider by the principal/declarant or by another to whom the principal/declarant has communicated the revocation.

5. It is the responsibility of the principal/declarant to provide the attending health care provider with a copy of this document.

6. A declaration relating to use of life-sustaining procedures will be given effect only when the declarant's condition is determined to be terminal or the declarant is in a state of permanent unconsciousness, and the declarant is not able to make treatment decisions.

### SUGGESTIONS AFTER FORM IS PROPERLY SIGNED, WITNESSED OR NOTARIZED

1. Place original in a safe place known and accessible to family members or close friends.
2. Provide a copy to your doctor.
3. Provide a copy(s) to family member(s).
4. Provide a copy to the designated attorney in fact (agent) and to alternate designated attorneys in fact (if any).

## AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION TO NOMINATED HEALTH CARE ATTORNEY-IN-FACT

Pursuant to the terms of a Durable Power of Attorney, Health Care Decisions, (or Combined Living Will and Medical Power of Attorney) (HCPOA) dated \_\_\_\_\_, in which the undersigned is the grantor, the power becomes effective in the event of my disability or incapacity.

### AUTHORIZATION TO RELEASE INFORMATION:

I authorize any physician, health care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy, or other covered health care provider, any insurance company and the Medical Information Bureau, Inc., or other health care clearinghouse that has provided treatment or services to me or that has paid for or is seeking payment from me for such services, to give, disclose, and release to the person or persons designated in this document to act as my agent such of my individually identifiable health information and medical records regarding any past, present or future medical or mental health condition

(including all specially protected health information relating to each of the following conditions specifically authorized by me to be disclosed by marking the box with an "X" or a check mark:

- ☐ sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), and human immunodeficiency virus (HIV);
- ☐ behavioral and mental health; and
- ☐ alcohol, drug and other substance abuse)

\_\_\_\_\_  
Signature of Principal

\_\_\_\_\_  
Date

relating to my ability to make health care decisions. The purpose of this request is to assist in determining whether the person designated to act as my agent should act as my agent. This authorization expires when I die or when revoked by me by a written revocation signed by me and delivered to the entity from which information is being requested prior to the time information is being requested.

I understand I can revoke this authorization by delivering a written statement of revocation to any entity I have authorized to give, disclose and release information. The revocation is effective only as to those entities to whom the written statement revocation is given and only after the time of delivery. I also understand that I have the right to inspect the disclosed information at any time. My treatment, payment, enrollment or eligibility for benefits with an entity that I have authorized to release information is not conditioned on my signing this authorization. I know that once the information I have authorized to be released is released it is subject to re-disclosure by the recipient and is no longer protected by the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated pursuant thereto, as amended from time to time.

### THE AUTHORITY TO ACT AS PERSONAL REPRESENTATIVE

In addition to the other powers granted by the HCPOA, I grant to my agent the power and authority to serve as my personal representative for all purposes of the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, and its regulations (HIPAA) during any time that my agent (hereinafter referred to in subsequent clauses of this paragraph as my "HIPAA personal representative") is exercising authority under this document.

Pursuant to HIPAA, I specifically authorize my HIPAA personal representative to request, receive and review any information regarding my physical or mental health, including without limitation all HIPAA-protected health information, medical and hospital records; to execute on my behalf any authorizations, releases, or other documents that may be required in order to obtain this information and to consent to the disclosure of this information. I further authorize my HIPAA personal representative to execute on my behalf any documents necessary or desirable to implement the health care decisions that my HIPAA personal representative is authorized to make under the HCPOA.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

\_\_\_\_\_  
, Grantor



## **Triage Cancer Estate Planning Toolkit**



### **Part III: Your State's Estate Planning Forms**



#### **Physician Orders for Life Sustaining Treatment (POLST)**

*Disclaimer: This toolkit is intended to provide general information on the topics presented. It is provided with the understanding that Triage Cancer is not engaged in rendering any legal, medical, or professional services by its publication or distribution. Although this content was reviewed by a professional, it should not be used as a substitute for professional services.*

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                              |                                                                                                                                                                                                                                                                                                           |              |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|
|  <p><b>Iowa Physician Orders<br/>for Scope of Treatment (IPOST)</b></p> <p>First follow these orders, <b>THEN</b> contact the physician, nurse practitioner or physician's assistant. This is a medical order sheet based on the person's current medical condition and treatment preferences. Any <b>section not completed implies full treatment for that section.</b> Everyone shall be treated with dignity and respect.</p> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | <b>Last Name</b>             |                                                                                                                                                                                                                                                                                                           |              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | <b>First/Middle Name</b>     |                                                                                                                                                                                                                                                                                                           |              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | <b>Date of Birth</b>         |                                                                                                                                                                                                                                                                                                           |              |
| <b>A</b><br>Check one                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | <b>CARDIOPULMONARY RESUSCITATION (CPR):</b> <u>Person has no pulse AND is not breathing.</u><br><input type="checkbox"/> CPR/Attempt Resuscitation<br><input type="checkbox"/> DNR/Do Not Attempt Resuscitation                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                              |                                                                                                                                                                                                                                                                                                           |              |
| <b>B</b><br>Check one                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | <b>MEDICAL INTERVENTIONS:</b> <u>Person has a pulse AND/OR is breathing.</u><br><input type="checkbox"/> <b>COMFORT MEASURES ONLY</b> Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. <b>Patient prefers no transfer to hospital for life-sustaining treatment. Transfer if comfort needs cannot be met in current location.</b><br><input type="checkbox"/> <b>LIMITED ADDITIONAL INTERVENTIONS</b> Includes care described above. Use medical treatment, cardiac monitor, oral/IV fluids and medications as indicated. <b>Do not</b> use intubation, or mechanical ventilation. May consider less invasive airway support (BiPAP, CPAP). May use vasopressors. <b>Transfer to hospital if indicated, may include critical care.</b><br><input type="checkbox"/> <b>FULL TREATMENT</b> Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation and cardioversion as indicated. <b>Transfer to hospital if indicated. Includes critical care.</b><br><b>Additional Orders:</b> _____ |                              |                                                                                                                                                                                                                                                                                                           |              |
| <b>C</b><br>Check one                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | <b>ARTIFICIALLY ADMINISTERED NUTRITION</b> Always offer food by mouth if feasible.<br><input type="checkbox"/> No artificial nutrition by tube.<br><input type="checkbox"/> Defined trial period of artificial nutrition by tube.<br><input type="checkbox"/> Long-term artificial nutrition by tube.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                              |                                                                                                                                                                                                                                                                                                           |              |
| <b>D</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | <b>MEDICAL DECISION MAKING</b><br><b>Directed by:</b> (listed in order of Iowa Code/Statute for Priority of Surrogates; check only one)<br><input type="checkbox"/> Patient<br><input type="checkbox"/> Durable Power of Attorney for Health Care<br><input type="checkbox"/> Spouse<br><input type="checkbox"/> Majority of Adult Children<br><input type="checkbox"/> Parents<br><input type="checkbox"/> Majority rule for nearest relative<br><input type="checkbox"/> Other: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                              | <b>Rationale for these orders:</b> (check all that apply)<br><input type="checkbox"/> Advance Directives<br><input type="checkbox"/> Patient's known preference<br><input type="checkbox"/> Limited treatment options<br><input type="checkbox"/> Poor prognosis<br><input type="checkbox"/> Other: _____ |              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Physician/ARNP/PA signature (mandatory)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Print Physician/ARNP/PA Name | Date                                                                                                                                                                                                                                                                                                      | Phone Number |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Patient/Resident or Legal Surrogate for Health Care Signature as identified above (mandatory)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                              |                                                                                                                                                                                                                                                                                                           | Date         |

SEND IPOST WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

DOCUMENT THAT IPOST FORM WAS TRANSFERRED WITH PERSON

Use of original form is strongly encouraged. Photocopies and Faxes of signed IPOST forms are legal and valid

**HIPAA PERMITS DISCLOSURE OF IPOST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY**

**Information for Person named on this Form**    **Person's Name (print)** \_\_\_\_\_

This form records your preferences for life-sustaining treatment in your **current** state of health. It can be reviewed and updated by your health care professional at any time if your preferences change. If you are unable to make your own health care decisions, the orders should reflect your treatment preferences as best understood by your surrogate.

**Contact Information**

|                      |              |              |
|----------------------|--------------|--------------|
| Surrogate (optional) | Relationship | Phone Number |
|----------------------|--------------|--------------|

**Directions For Health Care Professionals**

**Completing IPOST**

- Must be completed by a health care professional based on patient treatment preferences and medical indications.
- IPOST must be signed by a physician, nurse practitioner or physician's assistant to be valid. Verbal orders are acceptable with follow-up signature by physician, nurse practitioner or physician's assistant in accordance with facility/community policy.
- Use of original form is strongly encouraged. Photocopies and FAXes of signed IPOST forms are legal and valid.

**Using IPOST**

- Any section of the IPOST not completed implies full treatment for that section.
- A semi-automatic external defibrillator (AED) should not be used on a person who has chosen "Do Not Attempt Resuscitation" unless otherwise specified.
- Deactivation of internal defibrillators if comfort measures only are in effect.
- Medications by alternative routes of administration to enhance comfort may be appropriate for a person who has chosen "Comfort Measures Only."

**Voiding IPOST**

- A person with capacity, or the valid surrogate of a person without capacity, can void the form and request alternative treatment.
- To void this form, draw line through sections A through C and write "VOID" in large letters across the form and sign and date that line if IPOST is replaced or becomes invalid.
- Any changes require a new IPOST.

**Transferring/Discharging with IPOST**

- The IPOST form belongs to the person.
- The IPOST form **MUST** accompany the person upon all transfers between care settings.
- Document that the IPOST was sent with the person.
- Recommended use at home: Advise patient they must keep IPOST in easily accessible location that the ambulance service could find if no family or friends present (example may be in an envelope or baggie on the refrigerator).

**Reviewing IPOST**

- This IPOST should be reviewed periodically whenever:
  1. The person is transferred from one care setting or care level to another, or
  2. There is a substantial change in the person's health status, or
  3. The person's treatment preferences change.

|              |       |              |       |              |       |
|--------------|-------|--------------|-------|--------------|-------|
| Reviewed by: | Date: | Reviewed by: | Date: | Reviewed by: | Date: |
|              |       |              |       |              |       |
|              |       |              |       |              |       |

**Prepared by:**

|                                         |                |              |               |
|-----------------------------------------|----------------|--------------|---------------|
| Health Care Professional Preparing Form | Preparer Title | Phone Number | Date Prepared |
|-----------------------------------------|----------------|--------------|---------------|

**ORIGINAL TO ACCOMPANY PERSON IF TRANSFERRED OR DISCHARGED  
DOCUMENT THAT IPOST FORM WAS TRANSFERRED WITH PERSON**

Revised 01/21/09, 1/30/09, 07/6/09, 8/3/10, 6/25/12



## **Triage Cancer Estate Planning Toolkit**



### **Part III: Your State's Estate Planning Forms**



#### **HIPAA Authorization Form**

*Disclaimer: This toolkit is intended to provide general information on the topics presented. It is provided with the understanding that Triage Cancer is not engaged in rendering any legal, medical, or professional services by its publication or distribution. Although this content was reviewed by a professional, it should not be used as a substitute for professional services.*

## 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