



## Triage Cancer Estate Planning Toolkit: Maine

### 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.

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

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 (or a legally emancipated minor)
  - Of “sound mind” (meaning you know what you’re doing)
2. You need to sign the will, in front of two witnesses who have watched you sign or authorize someone else to sign the will, and understand what they are signing.
3. You might also want to make your will “self-proving,” or accepted in probate court without the court needing to contact your witnesses. To do this, you and your witnesses must sign a statement in front of a notary public.

The Maine state legislature created a statutory will form to make this process easier and more accessible. With this free will form, you can execute your will by filling in the blanks and signing it in front of two witnesses (who meet the same requirements as those for a written will).

The benefits of this statutory will are that it is free to complete, and you can complete it on your own, without hiring an attorney. The downside of a statutory will is that it cannot be customized. Therefore, statutory wills are best for very simple estates. Part III of this toolkit includes a sample form.

Maine allows for remote notarization of wills.

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

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

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

#### State Laws About Financial Powers of Attorney

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

In Maine, the general power of attorney form allows you to appoint someone (your “attorney-in-fact”) to oversee your finances and transactions, including buying, selling, managing, and repairing personal property, and making payments for you. You can also appoint a successor agent, and a second successor agent, in case the first person you choose cannot be your agent. You can allow this person to make all of these decisions, or add limits to their authority. With this form, you can indicate if you want it to take effect if you become incapacitated, and/or if it should take effect immediately. You can revoke your power of attorney at any time, as long as you can make decisions for yourself.

Part III of this toolkit 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 Maine, this document contains seven parts. You can complete the whole form or any part(s) of the document, but you must complete Part 6 to execute the directive.

1. **Power of Attorney for Health Care:** You can appoint someone (your “agent”) to make any and all health care decisions for you, if your doctor determines you can no longer make these decisions yourself for any reason. This can be as broad as to include life-sustaining care, or you can limit the powers of your agent. You can also choose an alternate person if the first person you appoint is not available.
2. **Special Instructions:** Sometimes called a “living will,” this document lets you indicate your preferences for life-sustaining care if you become unable to speak for yourself. You can provide preferences for specific treatments, like artificial nutrition and hydration.
3. **Primary Physician:** You can use this form to designate a physician you would like to be primarily responsible for your health care.
4. **Donation of Body, Organs or Tissues at Death:** You can indicate whether or not you would like to donate your body, organs, or tissues after your death.
5. **Instructions About Funeral and Burial Arrangements:** You can choose someone to make all funeral and burial decisions after your death, or tell your family any wishes you have about funeral and burial decisions.
6. **Execution:** In this section, you and your two witnesses must sign the document to make it legal. You aren’t required to have the form notarized, but it’s a good idea if you travel or live part of the year in a different state.
7. **Instructions to Emergency Medical Services about what to do if your heart or breathing stops:** Commonly called “Do Not Resuscitate (DNR) orders,” if you do not wish to be revived by ambulance crews should your heart or breathing stop, then you and your physician (or nurse practitioner or physician assistant) need to complete and sign this form.

Your advance health care directive goes into effect once your doctor determines you are unable to communicate your health care decisions.

If you change your mind about instructions in your directive, you can revoke any part of these instructions (except the appointment of your agent) in any way and at any time. This includes telling your agent or destroying the document. To revoke your agent’s power, tell your health care provider or make a written statement.

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

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

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

This form lets you indicate your preferences for:

- Cardiopulmonary resuscitation orders (also known as a “Do not resuscitate,” or DNR order)
- Medical Interventions, ranging from all medical and surgical treatments available to prolong your life, selective treatments to restore your health while avoiding burdensome procedures, or comfort-focused treatments to manage symptoms and allow natural death
- Medically assisted nutrition, or 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.

Maine does not have a separate funeral designation form, but you can appoint an agent to make funeral and burial decisions or provide instructions to your family about any wishes you have about funeral and burial decisions by using Part 5 of the 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.

As of 2019, Maine’s Death with Dignity Act allows adults with terminal illnesses to voluntarily request medication that would hasten death, from their physicians. Qualified patients must:

- Be 18 years or older
- Be mentally competent, or able to make health care decision for yourself
- Be a Maine resident
- Be diagnosed with an incurable terminal illness with a prognosis of less than six months to live
- Be able to take (eat, drink, swallow, or inject) the aid-in-dying medication by yourself

If you would like to request aid-in-dying medication, start by talking to your physician. Your conversation could include discussing alternative and additional therapies (like comfort care or pain management), ways to involve loved ones, and the effects and process of taking an aid-in-dying medication. After this conversation, you must:

- Verbally ask for the medication twice, at least 15 days apart
- Submit a written request for the medication using the required form. This request should come after your second verbal request.
- After receiving all three requests, your doctor will refer you to another doctor to verify your diagnosis and prognosis

Once you receive your aid-in-dying medication, you can choose where you administer it. However, this cannot be done in a public place. If your doctor refuses to administer an aid-in-dying medication, they are required to refer you to someone who will, if you request a referral.

Taking aid-in-dying medications will not affect your life insurance policy, if you have one.

### **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 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](http://www.cdc.gov/phlp/publications/topic/hipaa.html).



## **Triage Cancer Estate Planning Toolkit: Maine**

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

- Statutory Will
- Power of Attorney for Financial Affairs
- Advanced Health Care Directive
- Physician Order for Life-Sustaining Treatment (POLST)
- HIPAA Authorization Form



## **Triage Cancer Estate Planning Toolkit**



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



#### **Statutory Will**

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## §2-517. Statutory wills

**1. Form.** Any person may execute a will on the following form, and the will must be presumed to be reasonable. This section does not limit any spousal rights, rights to exempt property or other rights set forth elsewhere in this Code.

### Maine Statutory Will

#### NOTICE TO THE PERSON WHO SIGNS THIS WILL:

1. THIS STATUTORY WILL HAS SERIOUS LEGAL EFFECTS ON YOUR FAMILY AND PROPERTY. IF THERE IS ANYTHING IN THIS WILL THAT YOU DO NOT UNDERSTAND, YOU SHOULD CONSULT A LAWYER AND ASK THE LAWYER TO EXPLAIN IT TO YOU.

2. THIS WILL DOES NOT DISPOSE OF PROPERTY THAT PASSES ON YOUR DEATH TO ANY PERSON BY OPERATION OF LAW OR BY CONTRACT. FOR EXAMPLE, THE WILL DOES NOT DISPOSE OF JOINT TENANCY ASSETS OR YOUR SPOUSE'S ELECTIVE SHARE, AND IT WILL NOT NORMALLY APPLY TO PROCEEDS OF LIFE INSURANCE ON YOUR LIFE OR YOUR RETIREMENT PLAN BENEFITS.

3. THIS WILL IS NOT DESIGNED TO REDUCE DEATH TAXES OR ANY OTHER TAXES. YOU SHOULD DISCUSS THE TAX RESULTS OF YOUR DECISIONS WITH A COMPETENT TAX ADVISOR.

4. YOU CANNOT CHANGE, DELETE OR ADD WORDS TO THE FACE OF THIS MAINE STATUTORY WILL. YOU SHOULD MARK THROUGH ALL SECTIONS OR PARTS OF SECTIONS THAT YOU DO NOT COMPLETE. YOU MAY REVOKE THIS MAINE STATUTORY WILL AND YOU MAY AMEND IT BY CODICIL.

5. THIS WILL TREATS ADOPTED CHILDREN AS IF THEY ARE NATURAL CHILDREN.

6. IF YOU MARRY OR DIVORCE AFTER YOU SIGN THIS WILL, YOU SHOULD MAKE AND SIGN A NEW WILL.

7. IF YOU HAVE ANOTHER CHILD AFTER YOU SIGN THIS WILL, YOU SHOULD MAKE AND SIGN A NEW WILL.

8. THIS WILL IS NOT VALID UNLESS IT IS SIGNED BY AT LEAST TWO WITNESSES. YOU SHOULD CAREFULLY READ AND FOLLOW THE WITNESSING PROCEDURE DESCRIBED AT THE END OF THIS WILL.

9. YOU SHOULD KEEP THIS WILL IN YOUR SAFE-DEPOSIT BOX OR OTHER SAFE PLACE.

10. IF YOU HAVE ANY DOUBTS WHETHER OR NOT THIS WILL ADEQUATELY SETS OUT YOUR WISHES FOR THE DISPOSITION OF YOUR PROPERTY, YOU SHOULD CONSULT A LAWYER.

### MAINE STATUTORY WILL OF

.....

(Print your name)

#### Article 1. Declaration

This is my will and I revoke any prior wills and codicils.

#### Article 2. Disposition of my property

2.1 REAL PROPERTY. I give all my real property to my spouse, if living; otherwise it shall be equally divided among my children who survive me; except as specifically provided below: (specific distribution not valid without signature.)

I leave the following specific real property to the person(s) named:

| (name) | (description of item) | (signature) |
|--------|-----------------------|-------------|
| _____  | _____                 | _____       |
| _____  | _____                 | _____       |
| _____  | _____                 | _____       |
| _____  | _____                 | _____       |

2.2 PERSONAL AND HOUSEHOLD ITEMS. I give all my furniture, furnishings, household items, personal automobiles and personal items to my spouse, if living; otherwise they shall be equally divided among my children who survive me; except as specifically provided below: (specific distribution not valid without signature.)

I leave the following specific items to the person(s) named:

| (name) | (description of item) | (signature) |
|--------|-----------------------|-------------|
| _____  | _____                 | _____       |
| _____  | _____                 | _____       |
| _____  | _____                 | _____       |
| _____  | _____                 | _____       |

2.3 CASH GIFT TO CHARITABLE ORGANIZATIONS OR INSTITUTIONS. I make the following cash gift(s) to the named charitable organizations or institutions in the amount stated. If I fail to sign this provision, no gift is made. If the charitable organization or institution does not survive me or accept the gift, then no gift is made.

| (name) | (amount) | (signature) |
|--------|----------|-------------|
| _____  | _____    | _____       |
| _____  | _____    | _____       |
| _____  | _____    | _____       |

2.4 ALL OTHER ASSETS (MY "RESIDUARY ESTATE"). I adopt only one Property Disposition Clause by placing my initials in the box in front of the letter "A," "B" or "C" signifying which clause I wish to adopt. I place my signature after clause "A" or clause "B," or after each individual distribution in clause "C." If I fail to sign the appropriate distribution(s) or if I sign in more than one clause or if I fail to place my initials in the appropriate box, this paragraph 2.4 will be invalid and I realize that the remainder of my property will be distributed as if I did not make a will.

Property Disposition Clauses. (select one)

\_\_\_ A. I leave all my remaining property to my spouse, if living. If my spouse is not living, then in equal shares to my children and the descendants of any deceased child.

\_\_\_\_\_ (signature).

\_\_\_ B. I leave the following stated amount to my spouse and the remainder in equal shares to my children and the descendants of any deceased child. If my spouse is not living, that share shall be distributed in equal shares to my children and the descendants of any deceased child.

\_\_\_\_\_ (signature).

\_\_\_ C. I leave the following stated amounts to the persons named:

|        |          |             |
|--------|----------|-------------|
| _____  | _____    | _____       |
| (name) | (amount) | (signature) |
| _____  | _____    | _____       |
| (name) | (amount) | (signature) |
| _____  | _____    | _____       |
| (name) | (amount) | (signature) |
| _____  | _____    | _____       |
| (name) | (amount) | (signature) |
| _____  | _____    | _____       |
| (name) | (amount) | (signature) |

2.5 UNDISTRIBUTED PROPERTY. If I have any property that, for any reason, does not pass under the other parts of this will, all of that property shall be distributed as follows: (Draw a line through any unused space.)

\_\_\_\_\_ (this paragraph only valid if signed)

### Article 3. Nomination of guardian, conservator and personal representative

3.1 GUARDIAN. (If you have a child under 18 years of age, you may name at least one person to serve as guardian for the child.)

If a guardian is needed for any child of mine, then I nominate the first guardian named below to serve as guardian of that child. If the person does not serve, then the others shall serve in the order I list them. My nomination of a guardian is not valid without my signature.

|                 |       |             |
|-----------------|-------|-------------|
| FIRST GUARDIAN  | _____ | _____       |
|                 |       | (signature) |
| SECOND GUARDIAN | _____ | _____       |
|                 |       | (signature) |
| THIRD GUARDIAN  | _____ | _____       |
|                 |       | (signature) |

3.2 CONSERVATOR. (A conservator may be named to manage the property of a minor child. You do not need to name a conservator if you wish the guardian to act as conservator. If you wish to name a conservator in addition to a guardian, complete this paragraph 3.2. If you do not wish to name a separate conservator, do not complete this paragraph.)

I nominate the first conservator named below to serve as conservator for any minor children of mine. If the first conservator does not serve, then the others shall serve in the order I list them. My nomination of a conservator is not valid without my signature.

|                    |       |             |
|--------------------|-------|-------------|
| FIRST CONSERVATOR  | _____ | _____       |
|                    |       | (signature) |
| SECOND CONSERVATOR | _____ | _____       |
|                    |       | (signature) |
| THIRD CONSERVATOR  | _____ | _____       |
|                    |       | (signature) |

3.3 PERSONAL REPRESENTATIVE. (Name at least one.) I nominate the person or institution named as first personal representative below to administer the provisions of this will. If that person or institution does not serve, then I nominate the others to serve in the order I list them. My nomination of a personal representative is not valid without my signature.

FIRST PERSONAL REPRESENTATIVE \_\_\_\_\_  
 \_\_\_\_\_ (signature)

SECOND PERSONAL REPRESENTATIVE \_\_\_\_\_  
 \_\_\_\_\_ (signature)

THIRD PERSONAL REPRESENTATIVE \_\_\_\_\_  
 \_\_\_\_\_ (signature)

I sign my name to this Maine Statutory Will on \_\_\_\_\_ (date) at \_\_\_\_\_ (city) in the State of \_\_\_\_\_.

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

STATEMENT OF WITNESSES (You must have two witnesses.)

Each of us declares that the person who signed above willingly signed this Maine Statutory Will in our presence or willingly directed another to sign it for him or her or that he or she acknowledged that the signature on this Maine Statutory Will is his or hers or that he or she acknowledged that this Maine Statutory Will is his or her will and we sign below as witnesses to that signing.

Signature \_\_\_\_\_

Printed name \_\_\_\_\_

Address \_\_\_\_\_

Signature \_\_\_\_\_

Printed name \_\_\_\_\_

Address \_\_\_\_\_

Completing the following section and having all signatures acknowledged by a notary public or other individual authorized to take acknowledgments is optional but if completed will simplify the submission of your will to the probate court after your death.

I, \_\_\_\_\_, the testator, on this \_\_\_\_\_ day of \_\_\_\_\_, 20., being first duly sworn, do hereby declare to the undersigned authority that I sign and execute this instrument as my last will and that I sign it willingly (or willingly direct another to sign for me) as my free and voluntary act and that I am 18 years of age or older or am a legally emancipated minor, of sound mind and under no constraint or undue influence.

\_\_\_\_\_

Testator

We, \_\_\_\_\_, the witnesses, being first duly sworn, do hereby declare to the undersigned authority that the testator has signed and executed this instrument as (his)(her) last will and that (he)(she) signed it willingly (or willingly directed another to sign for (him)(her)), and that each of us, in the presence and hearing of the testator, signs this will as witness to the testator's signing, and that to the best of our knowledge the testator is 18 years of age or older or is a legally emancipated minor, of sound mind and under no constraint or undue influence.

\_\_\_\_\_

Witness

\_\_\_\_\_

Witness

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

County of .....

Subscribed, sworn to and acknowledged before me by ....., the testator, and  
subscribed and sworn to before me by ..... and ....., witnesses,  
this ..... day of .....

(Signed) .....

.....

(Official capacity of officer)

[PL 2017, c. 402, Pt. A, §2 (NEW); PL 2019, c. 417, Pt. B, §14 (AFF).]

**2. Forms provided.** Forms for executing a statutory will must be provided at all probate courts for a cost equivalent to the reasonable cost of printing and storing the forms. The probate courts shall make the statutory will form available via the Internet for free printing by anyone choosing to use the form. A statutory will is deemed to be valid if the blanks are filled in with a typewriter or in the handwriting of the person making the will. Failure to complete or mark through any section or part of a section in the statutory will does not invalidate the entire will. Failure to sign any section or part of a section in the statutory will requiring a signature invalidates only the part not signed, except as specifically provided in paragraph 2.4.

[PL 2017, c. 402, Pt. A, §2 (NEW); PL 2019, c. 417, Pt. B, §14 (AFF).]

#### SECTION HISTORY

PL 2017, c. 402, Pt. A, §2 (NEW). PL 2017, c. 402, Pt. F, §1 (AFF). PL 2019, c. 417, Pt. B, §14 (AFF).

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## **Triage Cancer Estate Planning Toolkit**



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



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

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# MAINE POWER OF ATTORNEY

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## IMPORTANT INFORMATION

Notice to the Principal: As the "Principal" you are using this power of attorney to grant power to another person (called the Agent) to make decisions about your property and to use your property on your behalf. Under this power of attorney you give your Agent broad and sweeping powers to sell or otherwise dispose of your property without notice to you. The powers that you give your Agent are explained more fully in the Maine Uniform Power of Attorney Act, Maine Revised Statutes, Title 18-C, Article 5, Part 9. You have the right to revoke this power of attorney at any time as long as you are not incapacitated. If there is anything about this power of attorney that you do not understand, you should ask an attorney to explain it to you.

## DESIGNATION OF AGENT

I, \_\_\_\_\_ [Principal name] of \_\_\_\_\_  
[Address], authorize \_\_\_\_\_ [Agent name] of \_\_\_\_\_  
\_\_\_\_\_, [Address], as my agent (attorney-in-fact) to act for me  
and in my name and for my use and benefit. If my agent is unable or unwilling to act for me, I name  
\_\_\_\_\_ [Successor name] of \_\_\_\_\_  
[Address], as my successor agent.

(Check if applicable. Strike out if not.)

## GRANT OF GENERAL AUTHORITY

I grant my agent and any successor agent general authority to act for me with respect to the following subjects:

INITIAL each subject you want to include in the agent's general authority.

INITIAL the line in front of "(O) All Preceding Subjects" if you wish to grant general authority over all of the subjects instead of initialing each subject.

\_\_\_\_\_ (A) Real property

\_\_\_\_\_ (B) Tangible personal property



- \_\_\_\_\_ (C) Stocks and bonds
- \_\_\_\_\_ (D) Commodities and options
- \_\_\_\_\_ (E) Banks and Other Financial Institutions
- \_\_\_\_\_ (F) Operation of Entity or Business
- \_\_\_\_\_ (G) Insurance and Annuities
- \_\_\_\_\_ (H) Estates, Trusts, and Other Beneficial Interests
- \_\_\_\_\_ (I) Claims and Litigation
- \_\_\_\_\_ (J) Personal and Family Maintenance
- \_\_\_\_\_ (K) Benefits from Governmental Programs or Civil or Military Service
- \_\_\_\_\_ (L) Retirement Plans
- \_\_\_\_\_ (M) Taxes
- \_\_\_\_\_ (N) Gifts
- \_\_\_\_\_ (O) All Preceding Subjects

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

My agent may **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.

- \_\_\_\_\_ (A) Create, amend, revoke, or terminate an inter vivos trust
- \_\_\_\_\_ (B) Make a gift
- \_\_\_\_\_ (C) Create or change rights of survivorship
- \_\_\_\_\_ (D) Create or change a beneficiary designation
- \_\_\_\_\_ (E) Authorize another person to exercise the authority granted under this power of attorney



\_\_\_\_\_ (F) Waive the principal's right to be a beneficiary of a joint and survivor annuity, including a survivor benefit under a retirement plan

\_\_\_\_\_ (G) Exercise fiduciary powers that the principal has authority to delegate

\_\_\_\_\_ (H) Disclaim property, including a power of appointment

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

An agent that is not my ancestor, spouse, or descendant may **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 Special Instructions.

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

You may give special instructions on the following lines:

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#### **EFFECTIVE DATE**

This power of attorney is effective immediately unless I have stated otherwise in the Special Instructions.

#### **TERMINATION** (Check one and strike out the other)

☐ **DURABLE** Power of Attorney. This power of attorney shall not be affected by my subsequent disability or incapacity, or lapse of time.

☐ **REGULAR** Power of Attorney. This power of attorney shall terminate if I become disabled or incapacitated.

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

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

Name of Nominee for guardian 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 OF PRINCIPAL**

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

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

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

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



State of Maine

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

On this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_, before me, \_\_\_\_\_,  
personally appeared \_\_\_\_\_, personally known to me or who proved to  
me on the basis of satisfactory evidence to be the person whose name is subscribed to this instrument  
and acknowledged to me that he/she executed the same and that by his/her signature on this instrument  
the person executed this instrument.

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

(Seal, if any)

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



## **IMPORTANT INFORMATION FOR AGENT**

Notice to the Agent: As the "Agent" you are given power under this power of attorney to make decisions about the property belonging to the Principal and to dispose of the Principal's property on the Principal's behalf in accordance with the terms of this power of attorney. This power of attorney is valid only if the Principal is of sound mind when the Principal signs it. When you accept the authority granted under this power of attorney, a special legal relationship is created between you and the Principal. This relationship imposes upon you legal duties that continue until you resign or the power of attorney is terminated or revoked. The duties are more fully explained in the Maine Uniform Power of Attorney Act, Maine Revised Statutes, Title 18-C, Article 5, Part 9 and Title 18-B, sections 802 to 807 and Title 18-B, chapter 9. As the Agent, you are generally not entitled to use the Principal's property for your own benefit or to make gifts to yourself or others unless the power of attorney gives you such authority. If you violate your duty under this power of attorney, you may be liable for damages and may be subject to criminal prosecution. 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 of termination are more fully explained in the Maine Uniform Power of Attorney Act and include, but are not limited to, revocation of your authority or of the power of attorney by the Principal, the death of the Principal or the commencement of divorce proceedings between you and the Principal. If there is anything about this power of attorney or your duties under it that you do not understand, you should ask an attorney to explain it to you.

### **Agent's Duties**

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

- (1) 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;
- (2) act in good faith;
- (3) do nothing beyond the authority granted in this power of attorney; and
- (4) 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:

- (1) act loyally for the principal's benefit;
- (2) avoid conflicts that would impair your ability to act in the principal's best interest;
- (3) act with care, competence, and diligence;
- (4) keep a record of all receipts, disbursements, and transactions made on behalf of the principal;
- (5) 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; and 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:

- (1) death of the principal;
- (2) the principal's revocation of the power of attorney or your authority;
- (3) the occurrence of a termination event stated in the power of attorney;
- (4) the purpose of the power of attorney is fully accomplished; or
- (5) 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 Maine Uniform Power of Attorney Act, Maine Revised Statutes, Title 18-A, Article 5, Part 9. If you violate the Maine Uniform Power of Attorney Act, Maine Revised Statutes, Title 18-A, Article 5, Part 9, 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.

### **AGENT'S CERTIFICATION AS TO THE VALIDITY OF POWER OF ATTORNEY AND AGENT'S AUTHORITY**

State of Maine  
County of \_\_\_\_\_

I, \_\_\_\_\_ (Name of Agent), certify under penalty of perjury that  
\_\_\_\_\_ (Name of Principal) granted me authority as an agent or successor agent  
in a power of attorney dated \_\_\_\_\_.

I, further certify that to my knowledge:

- (1) The Principal is alive and has not revoked the power of attorney or my authority to act under the power of attorney and the power of attorney and my authority to act under the power of attorney have not terminated;
- (2) If the power of attorney was drafted to become effective upon the happening of an event or contingency, the event or contingency has occurred;
- (3) If I was named as a successor agent, the prior agent is no longer able or willing to serve; and
- (4) \_\_\_\_\_  
\_\_\_\_\_ (Insert other relevant statements)



**SIGNATURE AND ACKNOWLEDGMENT OF AGENT**

Agent's Signature \_\_\_\_\_ Date \_\_\_\_\_

Agent's Name Printed: \_\_\_\_\_

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

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

This document was acknowledged before me on

\_\_\_\_\_ (Date), by \_\_\_\_\_ (Name of Agent).

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

(Seal, if any)

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

This document prepared by: \_\_\_\_\_





## **Triage Cancer Estate Planning Toolkit**



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



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

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# **Advance Health-Care Directive Form**

18-A M.R.S.A. §§ 5-801 - 5-817

**(See Instructions)**

## **PART 1—Selection of My Agent**

(Durable Power of Attorney for Health Care)

**(Sections 1 through 4)**

**(1) DESIGNATION OF AGENT:** I designate the following individual as my Agent to make health-care decisions for me:

\_\_\_\_\_  
(name of individual you choose as Agent)

\_\_\_\_\_  
(address)

\_\_\_\_\_  
(city) (state) (zip code)

\_\_\_\_\_  
(home phone)

\_\_\_\_\_  
(work phone)

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

\_\_\_\_\_  
(name of individual you choose as first alternate Agent)

\_\_\_\_\_  
(address)

\_\_\_\_\_  
(city) (state) (zip code)

\_\_\_\_\_  
(home phone)

\_\_\_\_\_  
(work phone)

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

\_\_\_\_\_  
(name of individual you choose as second alternate Agent)

\_\_\_\_\_  
(address)

\_\_\_\_\_  
(city) (state) (zip code)

\_\_\_\_\_  
(home phone)

\_\_\_\_\_  
(work phone)

**(2) AGENT'S AUTHORITY:**

My Agent is authorized to make all health-care decisions for me, including decisions to provide, withhold or withdraw artificial nutrition and hydration and all other forms of health care to keep me alive, except as I state here or in Part 2 of this form:

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

*(Add additional pages if needed.)*

*Authority under HIPAA:* I intend for my Agent herein appointed to be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records. I grant to my Agent the power and authority to serve as my Personal Representative for all purposes under the Health Insurance Portability and Accountability Act of 1996 and its regulations ("HIPAA"), 42 USC 1320d and 45 CFR 160-164.

**(3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: [check one box]**

☐ My Agent's authority becomes effective when my primary physician determines that I am unable to make my own health-care decisions.

**OR**

☐ My Agent's authority to make health-care decisions for me takes effect immediately and continues after I am no longer able to make decisions for myself.

**(4) AGENT'S OBLIGATION:** My Agent shall make health-care decisions for me in accordance with this power of attorney for health care, any specific instructions I give in Part 2 of this form and my other wishes to the extent known to my Agent. To the extent my wishes are unknown, my Agent shall make health-care decisions for me in accordance with what my Agent determines to be in my best interest. In determining my best interest, my Agent shall consider my personal values to the extent known to my Agent.

**You have the right to revoke Part 1 of this form at any time. You must do so in writing or by personally notifying your primary physician.**

18-A M.R.S.A. § 5-803

## **PART 2—Instructions for My Health Care**

### **(Sections 5 through 8)**

You need not fill out this part of the form if you are satisfied to allow your Agent to determine what is best for you in making end-of-life and other health care decisions. However, if you prefer, you can give your power of attorney specific instructions.

If you choose to fill out this part of the form, you may cross out any wording you do not want or add additional instructions at the end of any section or in section 8. ..If you cross out any wording, place your initials next to the part that you cross out.

**(5) END-OF-LIFE DECISIONS:** I direct that my health-care providers and others involved in my care provide, withhold or withdraw treatment in accordance with the choices I have noted below:

☐ Choice Not To Prolong Life

I do not want my life to be prolonged if: **[check all boxes that apply]**

☐ I have an incurable and irreversible condition that will result in my death within a relatively short time,

☐ I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness,

☐ the likely risks and burdens of treatment would outweigh the expected benefits,

☐ other \_\_\_\_\_

**OR**

☐ Choice To Prolong Life

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

**Other instructions:** \_\_\_\_\_

**(6) ARTIFICIAL NUTRITION AND HYDRATION: [check one box]**

☐ Artificial nutrition and hydration must be provided, withheld or withdrawn in accordance with the choice(s) I have made in paragraph (5);

**OR**

☐ Artificial nutrition and hydration must be provided regardless of my condition and regardless of the choice(s) I have made in paragraph (5).

**Other instructions:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**(7) RELIEF FROM PAIN:** I direct that treatment for alleviation of pain or discomfort **[check one box]**

☐ be provided at all times, even if it hastens my death:

**OR**

☐ **Other [state instructions]:** \_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

*(Add additional pages if needed)*

**You may revoke all or portions of Parts 2 to 5 of the advanced health care directive at any time and in any manner that communicates an intent to revoke.**

**18-A M.R.S.A. § 5-803**

## **PART 3—Donation of My Organs**

### **(Sections 9 and 10)**

**(9) Upon my death [check one box]**

☐ I do not wish to donate any organs.

☐ I give any needed organs, tissues or parts.

**OR**

☐ I give only the following organs, tissues or parts:

---

---

**(10) If I have decided to donate organs, my gift is for the following purposes:  
[check all boxes that apply]**

☐ Transplant

☐ Therapy

☐ Research

☐ Education

☐ Any of the above

☐ Other \_\_\_\_\_

## **PART 4—Choice of Primary Physician**

### **(Section 11)**

**(11) I designate the following physician as my primary physician:**

\_\_\_\_\_  
(name of physician)

\_\_\_\_\_  
(address)

\_\_\_\_\_  
(city) (state) (zip code)

\_\_\_\_\_  
(phone)

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

\_\_\_\_\_  
(name of physician)

\_\_\_\_\_  
(address)

\_\_\_\_\_  
(city) (state) (zip code)

\_\_\_\_\_  
(phone)

## **PART 5—Nomination of Guardian**

### **(Section 12)**

**(12)** If a probate court judge finds that a guardian must be appointed to make decisions for me:  
**[check one box]**

☐ I nominate the Agent designated in Part 1 of this form to be my guardian. If that Agent is not willing, able or reasonably available to act as guardian, I nominate the alternate Agents whom I have named, in the order designated.

**OR**

☐ I nominate the following person to serve as my guardian:

\_\_\_\_\_  
(name of proposed guardian)

\_\_\_\_\_  
(address)

\_\_\_\_\_  
(city) (state) (zip code)

\_\_\_\_\_  
(home phone)

\_\_\_\_\_  
(work phone)

## PART 6—Signatures

### YOUR SIGNATURE: (Required)

\_\_\_\_\_  
(sign your name)

\_\_\_\_\_  
(print your name)

\_\_\_\_\_  
(address)

\_\_\_\_\_  
(city) (state) (zip code)

\_\_\_\_\_  
(date)

### SIGNATURES OF TWO WITNESSES: (Required)

#### First witness

\_\_\_\_\_  
(signature of witness)

\_\_\_\_\_  
(print name)

\_\_\_\_\_  
(address)

\_\_\_\_\_  
(city) (state) (zip code)

\_\_\_\_\_  
(date)

#### Second witness

\_\_\_\_\_  
(signature of witness)

\_\_\_\_\_  
(print name)

\_\_\_\_\_  
(address)

\_\_\_\_\_  
(city) (state) (zip code)

\_\_\_\_\_  
(date)

**A copy of this form has the same effect as the original.**

18-A M.R.S.A. § 5-812

### Notary Acknowledgement (Optional)

Personally appeared before me the above-named \_\_\_\_\_ who took an oath and acknowledged this Advance Health Care Directive, including durable power of attorney for healthcare, as his/her free act and deed.

Date: \_\_\_\_\_

\_\_\_\_\_  
Notary Public State of: \_\_\_\_\_

Commission Exp.: \_\_\_\_\_

\_\_\_\_\_  
Print name



## **Triage Cancer Estate Planning Toolkit**



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



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

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## National POLST Form: A Portable Medical Order

Health care providers should complete this form only after a conversation with their patient or the patient's representative. The POLST decision-making process is for patients who are at risk for a life-threatening clinical event because they have a serious life-limiting medical condition, which may include advanced frailty ([www.polst.org/guidance-appropriate-patients-pdf](http://www.polst.org/guidance-appropriate-patients-pdf)).

### Patient Information.

### Having a POLST form is always voluntary.

This is a medical order,  
not an advance directive.  
For information about  
POLST and to understand  
this document, visit:  
[www.polst.org/form](http://www.polst.org/form)

Patient First Name: \_\_\_\_\_  
Middle Name/Initial: \_\_\_\_\_ Preferred name: \_\_\_\_\_  
Last Name: \_\_\_\_\_ Suffix (Jr, Sr, etc): \_\_\_\_\_  
DOB (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_ State where form was completed: \_\_\_\_\_  
Gender: ☐ M ☐ F ☐ X Social Security Number's last 4 digits (optional): xxx-xx-\_\_\_\_

### A. Cardiopulmonary Resuscitation Orders. Follow these orders if patient has no pulse and is not breathing.

|        |                                                                                                                                                                               |                                                                                                     |
|--------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|
| Pick 1 | <input type="checkbox"/> YES CPR: Attempt Resuscitation, including mechanical ventilation, defibrillation and cardioversion. (Requires choosing Full Treatments in Section B) | <input type="checkbox"/> NO CPR: Do Not Attempt Resuscitation. (May choose any option in Section B) |
|--------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|

### B. Initial Treatment Orders. Follow these orders if patient has a pulse and/or is breathing.

Reassess and discuss interventions with patient or patient representative regularly to ensure treatments are meeting patient's care goals. Consider a time-trial of interventions based on goals and specific outcomes.

|        |                                                                                                                                                                                                                                                                                                                                                                                                 |
|--------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Pick 1 | <input type="checkbox"/> Full Treatments (required if choose CPR in Section A). Goal: Attempt to sustain life by all medically effective means. Provide appropriate medical and surgical treatments as indicated to attempt to prolong life, including intensive care.                                                                                                                          |
|        | <input type="checkbox"/> Selective Treatments. Goal: Attempt to restore function while avoiding intensive care and resuscitation efforts (ventilator, defibrillation and cardioversion). May use non-invasive positive airway pressure, antibiotics and IV fluids as indicated. Avoid intensive care. Transfer to hospital if treatment needs cannot be met in current location.                |
|        | <input type="checkbox"/> Comfort-focused Treatments. Goal: Maximize comfort through symptom management; allow natural death. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Avoid treatments listed in full or select treatments unless consistent with comfort goal. Transfer to hospital <b>only</b> if comfort cannot be achieved in current setting. |

### C. Additional Orders or Instructions. These orders are in addition to those above (e.g., blood products, dialysis).

[EMS protocols may limit emergency responder ability to act on orders in this section.]

### D. Medically Assisted Nutrition (Offer food by mouth if desired by patient, safe and tolerated)

|        |                                                                                               |                                                                                       |
|--------|-----------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|
| Pick 1 | <input type="checkbox"/> Provide feeding through new or existing surgically-placed tubes      | <input type="checkbox"/> No artificial means of nutrition desired                     |
|        | <input type="checkbox"/> Trial period for artificial nutrition but no surgically-placed tubes | <input type="checkbox"/> Not discussed or no decision made (provide standard of care) |

### E. SIGNATURE: Patient or Patient Representative (eSigned documents are valid)

I understand this form is voluntary. I have discussed my treatment options and goals of care with my provider. If signing as the patient's representative, the treatments are consistent with the patient's known wishes and in their best interest.

|                                                                                               |                                         |            |                                                                                               |
|-----------------------------------------------------------------------------------------------|-----------------------------------------|------------|-----------------------------------------------------------------------------------------------|
|  (required) |                                         |            | The most recently completed valid POLST form supersedes all previously completed POLST forms. |
|                                                                                               | If other than patient, print full name: | Authority: |                                                                                               |

### F. SIGNATURE: Health Care Provider (eSigned documents are valid)

Verbal orders are acceptable with follow up signature.

I have discussed this order with the patient or his/her representative. The orders reflect the patient's known wishes, to the best of my knowledge. [Note: Only licensed health care providers authorized by law to sign POLST form in state where completed may sign this order]

|                                                                                               |                                               |                       |
|-----------------------------------------------------------------------------------------------|-----------------------------------------------|-----------------------|
|  (required) | Date (mm/dd/yyyy): Required<br>____/____/____ | Phone #: (____) _____ |
|                                                                                               | Printed Full Name:                            | License/Cert. #:      |
| Supervising physician signature:                                                              | <input type="checkbox"/> N/A                  | License #:            |

Patient Full Name:

## Contact Information (Optional but helpful)

Patient's Emergency Contact. (Note: Listing a person here does not grant them authority to be a legal representative. Only an advance directive or state law can grant that authority.)

|            |                                                                                                   |                                            |
|------------|---------------------------------------------------------------------------------------------------|--------------------------------------------|
| Full Name: | <input type="checkbox"/> Legal Representative<br><input type="checkbox"/> Other emergency contact | Phone #:<br>Day: (     )<br>Night: (     ) |
|------------|---------------------------------------------------------------------------------------------------|--------------------------------------------|

|                             |                   |
|-----------------------------|-------------------|
| Primary Care Provider Name: | Phone:<br>(     ) |
|-----------------------------|-------------------|

|                                                         |                                          |
|---------------------------------------------------------|------------------------------------------|
| <input type="checkbox"/> Patient is enrolled in hospice | Name of Agency:<br>Agency Phone: (     ) |
|---------------------------------------------------------|------------------------------------------|

## Form Completion Information (Optional but helpful)

|                                                                                                                                                       |                                                                                                                                                                                                                                                                                                  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Reviewed patient's advance directive to confirm no conflict with POLST orders:<br>(A POLST form does not replace an advance directive or living will) | <input type="checkbox"/> Yes; date of the document reviewed: _____<br><input type="checkbox"/> Conflict exists, notified patient (if patient lacks capacity, noted in chart)<br><input type="checkbox"/> Advance directive not available<br><input type="checkbox"/> No advance directive exists |
|-------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

|                                                |                                                                                                                                |                                                                                            |                                          |
|------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|------------------------------------------|
| Check everyone who participated in discussion: | <input type="checkbox"/> Patient with decision-making capacity<br><input type="checkbox"/> Legal Surrogate / Health Care Agent | <input type="checkbox"/> Court Appointed Guardian<br><input type="checkbox"/> Other: _____ | <input type="checkbox"/> Parent of Minor |
|------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|------------------------------------------|

|                                                                                               |                               |                     |
|-----------------------------------------------------------------------------------------------|-------------------------------|---------------------|
| Professional Assisting Health Care Provider w/ Form Completion (if applicable):<br>Full Name: | Date (mm/dd/yyyy):<br>/     / | Phone #:<br>(     ) |
|-----------------------------------------------------------------------------------------------|-------------------------------|---------------------|

This individual is the patient's: ☐ Social Worker ☐ Nurse ☐ Clergy ☐ Other:

## Form Information &amp; Instructions

- **Completing a POLST form:**
  - Provider should document basis for this form in the patient's medical record notes.
  - Patient representative is determined by applicable state law and, in accordance with state law, may be able execute or void this POLST form only if the patient lacks decision-making capacity.
  - Only licensed health care providers authorized to sign POLST forms in their state or D.C. can sign this form. See [www.polst.org/state-signature-requirements-pdf](http://www.polst.org/state-signature-requirements-pdf) for who is authorized in each state and D.C.
  - Original (if available) is given to patient; provider keeps a copy in medical record.
  - Last 4 digits of SSN are optional but can help identify / match a patient to their form.
  - If a translated POLST form is used during conversation, attach the translation to the signed English form.
- **Using a POLST form:**
  - Any incomplete section of POLST creates no presumption about patient's preferences for treatment. Provide standard of care.
  - No defibrillator (including automated external defibrillators) or chest compressions should be used if "No CPR" is chosen.
  - For all options, use medication by any appropriate route, positioning, wound care and other measures to relieve pain and suffering.
- **Reviewing a POLST form:** This form does not expire but should be reviewed whenever the patient:
  - (1) is transferred from one care setting or level to another;
  - (2) has a substantial change in health status;
  - (3) changes primary provider; or
  - (4) changes his/her treatment preferences or goals of care.
- **Modifying a POLST form:** This form cannot be modified. If changes are needed, void form and complete a new POLST form.
- **Voiding a POLST form:**
  - **If a patient or patient representative (for patients lacking capacity) wants to void the form:** destroy paper form and contact patient's health care provider to void orders in patient's medical record (and POLST registry, if applicable). State law may limit patient representative authority to void.
  - **For health care providers:** destroy patient copy (if possible), note in patient record form is voided and notify registries (if applicable).
- **Additional Forms.** Can be obtained by going to [www.polst.org/form](http://www.polst.org/form)
- As permitted by law, this form may be added to a secure electronic registry so health care providers can find it.

|                     |                           |
|---------------------|---------------------------|
| State Specific Info | For Barcodes / ID Sticker |
|---------------------|---------------------------|



## **Triage Cancer Estate Planning Toolkit**



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



#### **HIPAA Authorization Form**

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## 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