

## **INTRODUCTION TO YOUR COLORADO ADVANCE DIRECTIVE FOR HEALTHCARE**

Every adult needs an advance directive for healthcare. Regardless of age, regardless of health, none of us knows when a future event might leave us unable to speak for ourselves. If you become unable to make or communicate decisions about your medical treatment, a written record of your healthcare wishes would prove invaluable.

### **WHAT IS AN ADVANCE DIRECTIVE FOR HEALTHCARE?**

“Advance directive” is a generic term used for documents that traditionally include a living will and the appointment of a healthcare agent. These documents allow you to provide instructions relating to your future healthcare, such as when you wish to receive medical treatment or when you wish to stop or refuse life-sustaining medical treatments.

The “Living Will” portion of an advance directive is a place for you to specify what kinds of treatment and care you would or would not want if you were unable to speak for yourself. In Colorado, a living will is called the “Colorado Declaration as to Medical or Surgical Treatment.” The second part, often referred to as the “Colorado Medical Durable Power of Attorney for Healthcare,” allows you to appoint someone (an “Agent”) to act on your behalf in matters concerning your healthcare when you are unable to speak for yourself due to illness or incapacitation. Please note that the person you appoint to speak on your behalf may be called your healthcare agent, proxy, surrogate, or representative. Both parts are integrated in these advance directive documents which begin on page 13.

### **WHY IS IT USEFUL?**

Whereas traditional living wills are limited to cases of terminal illness, a healthcare advance directive is not. Rather, an advance directive helps you to maintain control over healthcare decisions that are important to you when you are unable to make or communicate decisions due to temporary or permanent injury or illness. An advance directive for healthcare allows you to express your wishes about any aspect of your healthcare, including decisions about life-sustaining treatment. It also allows you to choose a person to speak on your behalf and communicate your decisions when you are not able to do so. Appointing an agent and making sure your agent is aware of and understands your wishes is one of the most important things you can do. If the time comes for a decision to be made, your agent can participate in relevant discussions, weighing the pros and cons of treatment decisions based upon your wishes. Your agent can make healthcare decisions on your behalf whenever you cannot do so for yourself, even if your decision-making capacity is only temporarily affected. Another important consideration is your family: an advance directive helps relieve the stress and duress associated with having to make important healthcare decisions on behalf of someone they care about. By making your wishes known in advance, you help your family and friends, who may otherwise struggle to decide on their own, know what you would want done.

## **ARE ADVANCE DIRECTIVES FOR HEALTHCARE LEGALLY VALID IN EVERY STATE?**

Yes, advance directives are legally valid in every state. Each state (and the District of Columbia) has laws that permit individuals to sign documents stating their wishes about healthcare decisions when they cannot speak for themselves. The specifics of these laws vary, but the basic principle of listening to the patient's wishes is the same everywhere. The law gives great weight to any form of written directive. If the courts become involved, they usually try to follow the patient's stated values and preferences, especially if they are in written form. An advance directive for healthcare may be the most convincing evidence of your wishes you can create. It is important to note that while it is legal to have an advance directive in every state, no current law requires that they be strictly honored by healthcare professionals. Most states have reciprocity in their medical durable power of attorney statutes.

## **HOW DO I MAKE AN ADVANCE DIRECTIVE FOR HEALTHCARE?**

You do not need a lawyer to complete your advance directive. However, a lawyer may be helpful if your family situation is complex or if you expect problems to arise. If you wish, you can start by making a copy of the advance directive beginning on page 13. If there are portions of this document with which you disagree, it is legally acceptable for you to cross them out and write your initials in the margin.

The next step might be to share and discuss your advance directive with your agent(s) or other trusted friends or relatives.

Your primary healthcare providers are ALSO important participants to include in the creation of your advance directive. Based on your medical history and your current health, discuss the types of medical problems you may face. Your provider can help you to better understand potential treatment options. Make sure your provider clearly understands your treatment wishes and goals.

Compassion & Choices provides up-to-date state-specific information about advance directives. Take the time to consider what is important to you and seek advice so that your advance directive reflects your beliefs. If you would like help completing your advance directive for healthcare, call Compassion & Choices at 1-800-247-7421.

Colorado law requires that you sign your advance directive in the presence of two witnesses. These witnesses must also sign your advance directive. This is done to show that they know you and believe you to be of sound mind. Your witnesses must be at least 18 years old and cannot be any of the following: entitled to any portion of your estate under your last will and testament or by operation of law, your attending physician or any other treating physician, an employee of your attending physician or treating healthcare facility, or a patient in your treating healthcare facility. At this time, it is not required to have your advance directive notarized in Colorado. However, notarization will assist in interstate reciprocity, as well as emphasizing the legality of the document.

## **IF I CHANGE MY MIND, CAN I CHANGE OR CANCEL MY ADVANCE DIRECTIVE FOR HEALTHCARE?**

Yes, you can change or cancel your advance directive at any time. You can do this by notifying your agent and/or healthcare provider in writing of your decision to do so. It is best to destroy all copies of your old advance directive and create a new one. Make sure to provide copies of your new form to the appropriate individuals. Compassion & Choices recommends that you review your advance directive every year and re-sign and date it to indicate that this document continues to reflect your wishes.

## **CONTENTS**

In addition to the formal advance directive beginning on page 13 below, you will find a number of other documents here which are useful in end-of-life planning. The “MY LAST WISHES” form beginning on page 19 is not a strictly legal document, but it may be included as an addendum to your advance directive.

## **WHO SHOULD BE MY AGENT?**

One of the most important things you can do is to appoint an agent to speak for you if and when you are ever unable to do so for yourself. An agent has great power over your healthcare and should be carefully chosen. In normal circumstances, no one will be monitoring your agent and his/her decisions. To help avoid disagreements, we recommend selecting one primary agent and at least one alternate agent. Your alternate agent would speak on your behalf if your primary agent were unwilling or unable to speak for you. Your agent must agree to serve in this role. It might be important to specify that your healthcare agent bears no financial burden or liability if he/she agrees.

Likewise, agents are not entitled to any financial compensation for their time. Agents must be 18 or older, and have decisional capacity. If the agent is a spouse and the couple later divorces, legally separates or annuls the marriage, the agent is automatically removed unless otherwise expressly stated in the document.

Before deciding on an agent (and alternatives), ask yourself: “Are they assertive? Will they be able to make difficult and possibly emotional decisions? Do they live nearby? Are they comfortable talking about death? Will they respect my values and wishes?” Then, talk to them. Share your wishes and make sure they clearly understand what is important to you. Go over the medical directive section of your living will with them. Confirm their willingness to speak on your behalf. Take into consideration that your children or your parents may not necessarily be the best choices to be your agents. It is often very emotionally difficult for intimate relatives to allow their close ones to die, even though they intellectually may agree with your living will.

In Colorado, because we have no default surrogate decision-makers, it really is essential to appoint an agent. In addition to family, think about friends, colleagues, clergy, or professional advisors. If you cannot think of anyone, contact Compassion & Choices at 1-800-247-7421 for help in locating an agent.

If you do not appoint an agent, and your healthcare provider (or a court) determines that you lack decisional capacity, then a proxy for healthcare will be appointed. In order to accomplish this, a search will be conducted to locate an “interested party” such as a family member or friend. If no such person can be located, the facility will appoint a member of its organization to serve as the medical proxy.

## **HOW CAN I MAKE SURE HEALTHCARE PROVIDERS WILL FOLLOW MY ADVANCE DIRECTIVE?**

Currently, there are no state laws that oblige medical personnel to honor your advance directive. Some healthcare providers have values and opinions that do not agree with the wishes you have expressed on either ethical or medical grounds. Because of this, they may not want to follow the directions you provide in your advance directive.

Colorado law allows doctors to refuse to honor your advance directive on conscience grounds. However, they must help you find another physician willing to honor your wishes. While this is rare, it is important to be aware of its potential.

To help avoid this situation, talk to your healthcare providers ahead of time. Make sure they understand your wishes and are familiar with your advance directive documents. And make sure they are willing to honor them. If they object, work out the issues or find another healthcare provider.

Once your advance directive is completed and signed, provide a copy to your agent, all healthcare providers, close friends and relatives, and anyone else who may be involved with your care.

There is a process in progress to develop a Medical Orders for Scope of Treatment (MOST) document for Colorado, which should be implemented by the end of 2009. In some other states, this is also called “MOST,” although in other states it is referred to as Physician Orders for Life-Sustaining Treatment (POLST). In general, this form is intended for use by those with serious, chronic, or terminal illness and who are in treatment facilities. It is a one-page two-sided form which summarizes a person’s wishes regarding treatment at the end of life. It does not replace your advance directive but serves as a medical order which is easily transportable from one facility to another. When approved, it will be available in medical facilities and offices. It must be signed by the patient or by the healthcare agent, as well as by the physician, physician’s assistant, or advance-practice nurse (sometimes called “nurse practitioner.”).

## **DEVELOPING YOUR OWN PHILOSOPHY ABOUT LIVING AND DYING**

Since death is a part of every life, there are several reasons for giving thought to death before having to face the near approach of it. One reason is that you will handle it better if it is on your own terms as much as possible. Another is that it will be very helpful to those who care about you if they know definitely what your preferences are. Here are some questions about life as well as death, which may be helpful in thinking things through.

- Have you accepted the fact that you are going to die one day?
- Is it death or the process of dying that is of most concern?
- Have you thought about decisions and consequences of a terminal condition if that occurs?
- Have you had a friend or relative whose dying was a prolonged process, who lingered on long after he or she wanted only the release of death?
- Are you able to savor the small things in daily life, things that you perhaps used to take for granted?
- What are some of the things in life that bring you warm satisfaction to recall?
- Have you given thought to the meaning of life? If yes, do you consider a meaning in general, or the specific meaning of your own life at any given moment?
- Do you think it is important to establish a meaning of life?
- What would you think if at some point you felt that your life had lost all meaning? Examples: the death of someone dear to you, a terminal illness, when you have no control over your life, or feel that you have become "useless."
- Does death, then, have a connection with the meaningfulness of life?
- Does this quotation make sense to you? Do you want to amend it in some way? *Is there not a certain satisfaction in the fact that natural limits are set to the life of the individual, so that at its conclusion it may appear as a work of art?* - Albert Einstein
- If you had a terminal illness, at what point would you want the release of death?
  - Unbearable pain, with no possibility of relief
  - Unacceptable indignities such as helplessness and loss of self-control
  - Inability to recognize loved ones or to remember recent events
  - Delusion
  - Radical personality change (such as repeated angry outbursts for no reason)
  - Unwillingness to prolong the anguish of those you love as they watch you deteriorate and linger to no purpose
  - Unwillingness to see your life savings go to the dying industry rather than to those you love or to causes you believe in
  - Simple inability to enjoy living any longer under the given conditions of life and health.

(“DEVELOPING YOUR OWN PHILOSOPHY ABOUT LIVING AND DYING” continues on next page)

You may rate what is important to you by marking each blank with either 1, 2, 3, 4, or 5, "1" being the least important and "5" being the most.

- \_\_\_\_\_ I want to know the truth about my condition.
- \_\_\_\_\_ I want to take part in decision-making involving my health care.
- \_\_\_\_\_ I want my healthcare agent to participate in my healthcare decision-making if I am unable to decide for myself.
- \_\_\_\_\_ Letting nature "take its course".
- \_\_\_\_\_ Maintaining my quality of life.
- \_\_\_\_\_ Maintaining my dignity.
- \_\_\_\_\_ Maintaining my privacy.
- \_\_\_\_\_ Living as long as possible, regardless of quality of life.
- \_\_\_\_\_ Having physical mobility.
- \_\_\_\_\_ Having good eyesight.
- \_\_\_\_\_ Having good hearing.
- \_\_\_\_\_ Having reasonable mental capacity.
- \_\_\_\_\_ Being able to speak.
- \_\_\_\_\_ Being able to communicate with others nonverbally —writing, touching, blinking, etc.
- \_\_\_\_\_ Having independence and control in my life.
- \_\_\_\_\_ Avoiding being a burden on others.
- \_\_\_\_\_ Being comfortable and pain-free, even if it may hasten my death.
- \_\_\_\_\_ Leaving good memories for friends and family.
- \_\_\_\_\_ Leaving assets for family, friends, charities, etc.
- \_\_\_\_\_ Dying in a short while, as opposed to a lingering process.
- \_\_\_\_\_ Financial aspects.

Other thoughts and feelings regarding medical treatments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**QUESTIONS TO ASK YOUR DOCTOR**

It is important for you and your doctor to understand each other. The following list of questions should provide both of you with the information necessary for such an understanding.

(“DEVELOPING YOUR OWN PHILOSOPHY ABOUT LIVING AND DYING” continues on next page)

If your doctor intimidates you or belittles your questions, consider finding a more sympathetic physician. To facilitate the session between you and your doctor, bring the following with you:

- 1) This list of questions
- 2) A list of your vitamins, herbs, supplements, prescription and nonprescription drugs and their dosages
- 3) A list of your vital statistics, such as allergies, other conditions, surgeries
- 4) A friend or family member
- 5) Copies of your Medical Durable Power of Attorney, advance directive, Living Will, Last Wishes

Make sure your physician is aware that your documents include HIPAA authorization to release your records to your agents and other necessary persons.

### **Questions regarding tests**

- 1) What tests will be performed for diagnosis?
- 2) What are the risks and reliability of these tests?
- 3) How long will it take to get results?
- 4) Will I need to take time off from work for these tests?

### **Questions regarding your condition**

- 1) What is the diagnosis?
- 2) Are there alternate diagnoses?
- 3) What is the prognosis?
- 4) How long will I need this treatment?
- 5) If the treatment is unsuccessful, would you accept the terms of my Living Will and my Medical Durable Power of Attorney?

### **Questions regarding medication**

- 1) How will the medication help my condition?
- 2) What are the side effects of this treatment?
- 3) How long will I need to take the medication?
- 4) Will this medication interfere with other medications I am taking?

### **Questions before surgery**

- 1) What are the goals of surgery?
- 2) What are the alternatives to surgery?
- 3) What is the surgical procedure?
- 4) What are the choices of anesthesia?
- 5) What are the risks of surgery?
- 6) How long will it take to recover from surgery?
- 7) If treatment is unsuccessful and there is NO hope of recovery, would you explore with me and my agent options on dying? If my condition is hopeless, would you be willing to help me to die? If family members disagree, would you continue to be my advocate?

(“CONSENT: RELEASE OF MEDICAL RECORDS” begins on next page)

**COMPASSION & CHOICES OF COLORADO  
CONSENT: RELEASE OF MEDICAL RECORDS**

- A.** Patient requesting release of Medical Records: \_\_\_\_\_
- B.** Medical Records requested from all who hold such records, including but not limited to:  
\_\_\_\_\_  
and any other person in the medical field who holds my records
- C.** Who is to receive the Medical Records: \_\_\_\_\_

I, the patient ("A" above) hereby authorize the holder(s) ("B" above) of my confidential medical records and information named above to share and discuss any and all medical, mental health, social work, legal, or other treatment and confidential information concerning me, and to provide copies of same to the persons named in (C) above. I or my estate will cover the costs incurred.

**PURPOSES AND EFFECTS OF THIS CONSENT:**

I have asked the advocacy program of Compassion & Choices of Colorado — and specifically those named in "C" above — to intervene regarding my care, treatment and support in the event I cannot speak for myself.

This Consent will assist my patient advocate(s) to communicate with the holders of my confidential medical records regarding my needs for consenting to or refusing healthcare. I intend for any agent serving hereunder to be treated as my "personal representative" as defined in 45 CFR 164.502(g) of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), so as to have all authority and rights that I would personally have with respect to the use and disclosure of my individually identifiable protected health information or other medical records. I recognize that information disclosed by a covered entity pursuant to this authorization is subject to further disclosure and may no longer be protected by the HIPAA privacy rules.

This release shall expire one year after my death unless earlier revoked in writing.

Effective Date: This Consent is effective from the date of signature.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

## COMPASSION & CHOICES OF COLORADO MEDICAL INFORMATION FORM

Patient's Name \_\_\_\_\_ Phone \_\_\_\_\_  
 Date of Birth \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Below are the names and phone numbers of the Compassion & Choices advocacy persons I have designated to be my proxy if I am unable to make or oversee the execution of healthcare decisions for myself.

Advocate's Name \_\_\_\_\_ Home Phone \_\_\_\_\_  
 Address \_\_\_\_\_ Other Phone \_\_\_\_\_

Alternate \_\_\_\_\_ Home Phone \_\_\_\_\_  
 Address \_\_\_\_\_ Other Phone \_\_\_\_\_

Doctor's name and phone

\_\_\_\_\_  
 Other doctor's name and phone

Provide your advance directive (Living Will, Medical Durable Power of Attorney) and, if you have one, your non-hospital Do-Not-Resuscitate (DNR) order with this form. If your lawyer has a copy, give his or her name and phone number. Give a copy of this form to your attorney.

Attorney's name \_\_\_\_\_ Phone \_\_\_\_\_

Have you discussed your wishes with your doctor(s)? \_\_\_\_\_

With your family? \_\_\_\_\_

With anyone else? \_\_\_\_\_

Name \_\_\_\_\_

Name \_\_\_\_\_

Are there people who may disagree with your wishes? If so, who?

Name \_\_\_\_\_

Name \_\_\_\_\_

What might these persons do?

Are there any other concerns?

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

**INSTRUCTIONS REGARDING THE COLORADO  
NOTICE OF PATIENT OR AUTHORIZED AGENT'S  
DIRECTIVE TO WITHHOLD CPR  
AND THE DNR FORM**

On the following page is a copy of the Notice of Patient or Authorized Agent's Directive to Withhold Cardiopulmonary Resuscitation (CPR) for the state of Colorado and a copy of the DNR form, which can be obtained only from physicians and must be filled out and signed in triplicate by the patient or patient's legal agent and attending physician

In Colorado, there is a legal mandate that requires EMTs responding to a 911 call to perform cardiopulmonary resuscitation (CPR) when indicated, unless they can be shown a do-not-resuscitate (DNR) form or the patient is wearing a DNR bracelet or necklace.

Bracelets or necklaces may be purchased from Awards and Signs, Ltd, 6801 S. Dayton, Greenwood Village, CO 80112, 303-799-8979. Orders must include both a check and the pink sheet of the signed DNR form.

The actual form begins on the following page.

## COLORADO DIRECTIVE FOR WITHHOLDING CPR

Notice of Patient or Authorized Agent's Directive  
to Withhold Cardiopulmonary Resuscitation (CPR)  
State of Colorado

Patient's Name: \_\_\_\_\_

Name of authorized agent, proxy, guardian/parent(s) of minor child (if applicable) \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Gender: Male Female Eye Color: \_\_\_\_\_ Hair Color: \_\_\_\_\_  
Race/Ethnicity: \_\_\_\_\_Asian or Pacific Islander \_\_\_\_\_Black, Non-Hispanic \_\_\_\_\_White, non-Hispanic  
\_\_\_\_American Indian or Alaska Native \_\_\_\_Hispanic \_\_\_\_Other

Name of hospice program (if applicable):

Attending Physician's Name \_\_\_\_\_

Physician's Address: \_\_\_\_\_

Physician's telephone: (\_\_\_\_) \_\_\_\_\_ Physician's License #: \_\_\_\_\_

Directive made on this date: \_\_\_\_\_, pursuant to Colorado Revised Statute 15-18.6-101.  
(month, day, year)

Check only one of the following (as appropriate):

Patient: I am over the age of 18 years, of sound mind and acting voluntarily. It is my desire to initiate this directive on my behalf, and I have been advised that the expected result of executing this directive is my death, in the event that my heart or breathing stops or malfunctions.

Authorized agent/proxy/legally authorized guardian/parent(s) of minor child: I am over the age of 18 years, of sound mind, and I am legally authorized to act on behalf of the patient named above in the issuance of this directive. I have been advised that the expected result of executing this directive is the death of the patient, in the event the patient's heart or breathing stops or malfunctions.

I hereby direct emergency medical services personnel, healthcare providers, and any other person to withhold cardiopulmonary resuscitation in the event that my/the patient's heart or breathing stops or malfunctions. I understand that this directive does not apply to other medical interventions for comfort care. If I/the patient am/is admitted to a healthcare facility, this directive shall be implemented as a physician's order, pending further physician's orders.

(“COLORADO DIRECTIVE FOR WITHHOLDING CPR” continues on page 12)

*Use of original signatures on each page of this form makes each page an original document.*

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Signature of :

Patient or  Authorized agent/proxy/legally authorized guardian/parent(s) of minor child

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Signature of Attending Physician

Consent to the following tissue donation is optional. These tissue donations do not require resuscitation:

**I hereby make an anatomical gift, to be effective upon my death, of: Any needed tissues.**

**The following tissues:** skin    cornea    bone    related tissues and tendons.

Donor/Agent Signature: \_\_\_\_\_

*The CPR program is being administered by the Colorado Department of Public Health & Environment. CPR directive forms administered by the CDPHE contain the blue "CPR" design in the background and the Colorado Directive logo.*

## **ADVANCE DIRECTIVE: MEDICAL DURABLE POWER OF ATTORNEY**

By this document, I intend to create a Medical Durable Power of Attorney, provide an advance directive for treatment when I am in a terminal state, and make a Declaration as to Medical or Surgical Treatment (a Living Will). Third parties may rely on the representations of my Agent who is designated to serve my interest.

I, (name) \_\_\_\_\_,  
of (city and state) \_\_\_\_\_, the Principal, hereby  
appoint (name of Agent) \_\_\_\_\_,  
of (city and state) \_\_\_\_\_, to serve as my Agent  
and to exercise the powers set forth below. If my Agent ceases to act due to inability or  
unwillingness to continue to serve, I hereby designate (name of first substitute Agent)  
\_\_\_\_\_ of (city and state) \_\_\_\_\_  
as my first substitute Agent. If my substitute ceases to act due to inability or unwillingness to  
continue to serve, I designate (name of second substitute Agent,  
\_\_\_\_\_  
of (city and state) \_\_\_\_\_

### **EFFECTIVE DATE AND DURABILITY**

By this document I intend to create a Medical Durable Power of Attorney effective upon, and only during, any period of disability or incapacity in which, in the opinion of my attending physician, I am unable to make or communicate responsible decisions regarding medical treatment or healthcare for myself.

### **AGENT POWERS**

I grant to my Agent full authority to make decisions for me regarding my medical treatment and healthcare. In exercising this authority, my Agent shall follow my desires as stated in my Declaration as to Medical or Surgical treatment. In making decisions, my Agent shall attempt to discuss the proposed decision with me to determine my desires if I am able to communicate in any way. If my Agent cannot determine the choice I would want made, then my Agent shall make a choice for me based upon what my Agent believes to be in my best interests. My Agent's authority to interpret my desires is intended to be as broad as possible, except for any limitations I may state below. Accordingly, my Agent is authorized as follows:

(a) To consent, refuse, or withdraw consent to any and all types of medical care, treatment, surgical procedures, diagnostic procedures, medication, and the use of mechanical or other procedures that affect bodily function, including (but not limited to) artificial respiration, artificial nourishment and hydration, and cardiopulmonary resuscitation;

(“ADVANCE DIRECTIVE” form continues on page 14)

- (b) To have access to my medical records and information to the same extent that I am entitled, including the right to disclose the contents to others;
- (c) To authorize my admission to or discharge from (even against medical advice) any hospital, nursing home, residential care, assisted living, or similar care facility or service;
- (d) To contract on my behalf for any healthcare-related service or facility, without my Agent's incurring personal financial liability for such contracts;
- (e) To retain and discharge medical, social service and other support personnel responsible for my care;
- (f) To authorize any medication or procedure intended to relieve pain for me, even though such use may lead to physical damage or addiction, or may hasten the moment of (but not intentionally cause) my death;
- (g) To make anatomical gifts of part or all of my body for medical purposes, authorize an autopsy, and then direct the disposition of my remains, to the extent permitted by law;
- (h) To take any other action necessary to implement my preference as to my healthcare as expressed herein or elsewhere, including (but not limited to) granting any waiver or release from liability required by any hospital, physician, or other healthcare provider; signing any documents relating to a refusal of treatment or the discharge from a facility against medical advice; and pursuing any legal action in my name and at my or my estate's expense to force compliance with my wishes as determined by my Agent, including claims for actual or punitive damages for any such failure to comply.

## **ACCESS TO MEDICAL RECORDS AND OTHER PERSONAL INFORMATION**

My Agent shall have the power to request, receive, review and release any information, including drug and alcohol treatment information, mental health information, medical and hospital records and other data having special protections under the law, specifically including the Health Insurance Portability and Authorization Act of 1996 (HIPAA), regarding my physical or mental health; and to execute any releases, waivers, insurance forms, or other documents that may be requested in order to obtain such information; or to obtain government assistance or insurance payment for any service rendered to me or for my benefit. Each person nominated to be my Agent shall specifically be authorized to receive all personal health information and documents necessary to determine my incapacity as if such person were already acting as my Agent.

**Granting Releases.** My Agent, on behalf of me, my heirs and my estate, shall have the power to grant waivers or releases from liability to healthcare providers and other persons or covered entities (as defined under HIPAA) involved in providing healthcare services for me or maintaining my protected health information and other healthcare records who act in reliance on instructions given by my Agent for the purpose of carrying out the provisions of this document.

**RELEASE OF INFORMATION.** I hereby authorize all "covered entities" as defined under the Health Insurance Portability and Authorization Act of 1996 ("HIPAA") (including physicians and

all other providers of healthcare services, mental healthcare, drug and alcohol treatment, hospitals, residential care facilities, insurance providers and medical information processors) to release to my Agent, or to my Agent's designee, all individually identifiable protected health information or photocopies of any records which my Agent may request in order to carry out my Agent's responsibilities hereunder. I hereby waive all privileges which may be applicable to such information and records and to any communication pertaining to my health and made in the course of any confidential relationship recognized by the law, specifically including the Health Insurance Portability and Authorization Act of 1996 (HIPAA). I understand that any protected health information released to my Agent or nominee is not protected from further disclosure, as my Agent deems necessary or advisable. This release shall terminate upon revocation of this Power of Attorney.

### **DECLARATION AS TO MEDICAL OR SURGICAL TREATMENT**

**(a)** If I should either: 1) Have an incurable injury, illness or disease; 2) be in a prolonged, and/or irreversible comatose or persistent vegetative state; or 3) be in an advanced stage of progressive dementia in which I am unable to coherently communicate, swallow food and water safely, care for myself, and recognize my family and other people, and if two physicians certify in writing that there is no reasonable probability of recovery from these conditions, then I direct that such procedures listed below, where I have written and initialed "yes," be withheld or withdrawn and that I be permitted to die naturally. Such life-sustaining procedures include, but are not limited to, the following:

- \_\_\_\_\_ (1) Surgery, unless it is absolutely necessary to control pain
- \_\_\_\_\_ (2) Antibiotics (using drugs to fight infection), when they will not significantly improve my comfort
- \_\_\_\_\_ (3) Cardiopulmonary resuscitation including electronic shock in the event of cardiac arrest
- \_\_\_\_\_ (4) Invasive diagnostic tests
- \_\_\_\_\_ (5) Intubation (insertion of a tube to admit air or administer gases)
- \_\_\_\_\_ (6) Respirator support (breathing by machine)
- \_\_\_\_\_ (7) Artificial hydration and nutrition (giving food and fluid through a tube in the veins, nose or stomach)
- \_\_\_\_\_ (8) Blood or blood products (such as transfusions)
- \_\_\_\_\_ (9) Kidney dialysis
- \_\_\_\_\_ (10) Heart-regulating drugs, including electrolyte replacement, if my heartbeat becomes irregular
- \_\_\_\_\_ (11) Cortisone or other steroid therapy, if tissue swelling threatens vital centers in my brain
- \_\_\_\_\_ (12) Stimulants, diuretics or any other treatment for heart failure, if the strength and function of my heart is impaired
- \_\_\_\_\_ (13) The withholding of administration of pneumonia vaccine

**(b)** Such person as I appoint with this Medical Durable Power of Attorney for healthcare, after consultation with my physician or a physician of my Agent's choosing, may use such person's best judgment to distinguish between treatments that are humane and those that only postpone the moment of death.

**(c)** Specifically in regard to NOURISHMENT AND HYDRATION, I have checked and initialed the following items I agree with:

\_\_\_\_\_(1) If I am incompetent but conscious, and unable or unwilling to eat or to be fed in the usual manner, I declare my wish to voluntarily stop eating and drinking by mouth and to refuse tube feeding through my nose and/or throat and/or through any surgical insertion of a tube, or through intravenous feeding except insofar as is necessary to provide comfort only, but not to maintain life, as determined by my attending physician and approved by my Agent.

\_\_\_\_\_(2) If I am unconscious and the only procedure being administered to me is tube or intravenous feeding, once my physician and consultant (with special competence in neurology) have established that there is not a reasonable likelihood that I will ever return to a conscious state with the ability to be oriented and to interact in a reasonably unimpaired way with my environment (such as the condition sometimes called the Permanent or Persistent Vegetative State), I declare my wish to have such artificial feeding withheld or withdrawn. I am aware that this may hasten my death, but I consider it against my interests and the interests of my survivors to have my body artificially maintained after reasonable hope of mental recovery is gone.

**(d)** With respect to any life-sustaining treatment, I specifically direct my Agent and my attending physician to follow the Declaration as to Medical or Surgical Treatment executed by me and this Medical Durable Power of Attorney. To the extent that any of the provisions of this Medical Durable Power of Attorney are deemed to conflict with my Declaration as to Medical or Surgical Treatment, my Declaration shall prevail. Notwithstanding any limitations that may be inferred from the terms of my Declaration as to Medical or Surgical Treatment, I do not want my life to be prolonged nor do I want life-sustaining treatment to be provided or continued if my Agent believes the burdens of the treatment outweigh the expected benefits. I want my Agent and attending physician to consider relief from suffering, expense involved, and quality of life as well as the mere prolongation of the moment of death in making decisions concerning life-sustaining treatment.

#### **EXCULPATION:**

**(a)** My Agent and my Agent's estate, heirs, successors, and assigns are hereby released and forever discharged by me, my estate, heirs, successors, and assigns from all liability and from all claims or demands of all kinds arising out of the acts or missions of my Agent. No person who relies in good faith upon any representations by my Agent or Successor Agent shall be liable to me, my estate, my heirs or my successors or assigns for recognizing the Agent's authority.

(b) Any physician, nurse, or other individual acting on my behalf is authorized and directed to follow these instructions. No physician signing a certificate of terminal condition and no physician, hospital or hospital personnel withholding or withdrawing life-sustaining procedures in compliance with this declaration, in the absence of actual knowledge of revocation or fraud, misrepresentation, or improper execution, shall be subject to civil liability, criminal penalty, or licensing sanctions therefor. On behalf of myself, my Agent, my family and my heirs and devisees, I hereby release any person who acts in reliance on the foregoing sentence from any claim or liability for any injury to me or arising by reason of my death.

### **NOMINATION OF GUARDIAN**

If a guardian of my person should for any reason be appointed, I nominate my Agent (or successor) named above.

### **ADMINISTRATIVE PROVISIONS**

- (a) I revoke all prior powers of attorney or advance directives for healthcare.
- (b) This Medical Durable Power of Attorney, advance directive and Declaration is intended to be valid in any jurisdiction in which it is presented.
- (c) My Agent shall not be entitled to compensation for services performed under this Medical Durable Power of Attorney, but my Agent shall be entitled to reimbursement by me or by my estate for all reasonable expenses incurred as a result of carrying out any provision hereunder.
- (d) The powers delegated under this document are separable, so that the invalidity of one or more powers shall not affect any others.
- (e) Photocopies of this document shall be as effective as the original. I specifically direct my Agent to have photocopies of this document placed in my medical records.

**BY SIGNING HERE I INDICATE THAT I UNDERSTAND THE CONTENTS OF THIS DOCUMENT AND THE EFFECT OF THIS GRANT OF POWERS TO MY AGENT. I AM OF SOUND MIND AND WILLFULLY AND VOLUNTARILY EXECUTE THIS DOCUMENT.**

I sign my name to this Medical Durable Power of Attorney, advance directive and Declaration on this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_. My current home address is \_\_\_\_\_.

Signature: \_\_\_\_\_

### **ACCEPTANCE OF APPOINTMENT**

The undersigned accept appointment as Agents under this Medical Durable Power of Attorney.

**Agent:** \_\_\_\_\_ Home Phone: \_\_\_\_\_

Signature: \_\_\_\_\_ Other Phone: \_\_\_\_\_

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

**1st Substitute Agent:** \_\_\_\_\_ Home Phone: \_\_\_\_\_

Signature: \_\_\_\_\_ Other Phone: \_\_\_\_\_

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

**2nd Substitute Agent:** \_\_\_\_\_ Home Phone: \_\_\_\_\_

Signature: \_\_\_\_\_ Other Phone: \_\_\_\_\_

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

**WITNESS STATEMENT**

I hereby declare that \_\_\_\_\_, who signed or acknowledged this document, is personally known to me, that he/she signed or acknowledged this Medical Durable Power of Attorney, advance directive and Declaration in my presence, and that he/she appears to be of sound mind and under no duress, fraud, or undue influence. I am not the person appointed as Agent by this document, nor am I the patient's healthcare provider or an employee of the patient's healthcare provider. I further declare that I am not related to the Principal by blood, marriage, or adoption, and to the best of my knowledge, I am not a creditor of the Principal nor entitled to any part of his or her estate under a will now existing or by operation of law.

**Witness No. 1**

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

Print Name: \_\_\_\_\_ Phone: \_\_\_\_\_

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

**Witness No. 2**

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

Print Name: \_\_\_\_\_ Phone: \_\_\_\_\_

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

**STATE OF COLORADO**

**CITY** \_\_\_\_\_ **COUNTY** \_\_\_\_\_

Subscribed and sworn to before me by \_\_\_\_\_, the Principal, and \_\_\_\_\_ and \_\_\_\_\_, as witnesses, as the voluntary act and deed of the Principal, this \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

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

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

**MY LAST WISHES**  
**An Addendum to My Advance Directive**  
**and My Medical Durable Power of Attorney**

I, as a person of clear and sound mind and under no coercion, endorse the items **INITIALED** on this directive. I do so with the understanding that there is a chance that none of these eventualities will befall me or that they all might. My wishes stated here have been carefully considered.

\_\_\_ They have been discussed with persons whom I have appointed as my healthcare agents.

\_\_\_ My agents agree with my wishes.

\_\_\_ This addendum is a supplement to and does nothing to negate my Advance Directives and my Medical Durable Power of Attorney but is appended to ensure that my additional wishes will be known by all who may care for me. This cannot cover all possibilities, but it particularly applies to irreversible brain conditions where there is a strong likelihood that cognitive function cannot be restored, where I cannot speak for myself and where there is no life support to disconnect so that death could occur easily.

\_\_\_ I wish to die with dignity and in peace. It is important for me to know that I will not have to die a lingering and/or demeaning death or endure a hopeless and severely disabling condition which would involve great suffering for myself and/or those I love. I would like to choose when and how I die and to seek help in carrying out that decision.

\_\_\_ To further indicate that this is an enduring request, I have been a member of the Hemlock Society, which is now called Compassion & Choices, since \_\_\_\_\_.

\_\_\_ It should be clear that despite my wish to choose death, I want the best possible medical care, including life-sustaining measures when the prognosis appears to be favorable and if there is a reasonable chance that I will be restored to independent living that has meaning and offers enjoyment.

**TO THOSE WHO CARE ABOUT ME:**

\_\_\_ If I am ill and homebound or in a hospital or nursing home, I would ask those persons who are close to me not to abandon me but to visit as much as I or they can tolerate, and to insure that I have adequate care and that my wishes are carried out.

\_\_\_ I would ask that you respect my view of dying and death and not try to impose your philosophy or beliefs on me, no matter how well-meaning. Quality of life and autonomous decision-making are high priorities for me.

**STATEMENT OF DESIRES:**

\_\_\_ I want all the provisions of my advance directive to be implemented.

\_\_\_ My preference would be to die (circle one): at home; in a hospice; in a hospital; other (specify) \_\_\_\_\_.

(“MY LAST WISHES” form continues on next page)

\_\_\_ I desire (circle one): cremation, burial, donation to medical facility (specify) \_\_\_\_\_

\_\_\_ I would like (circle one): memorial service; funeral; neither; other \_\_\_\_\_.

**BY SIGNING HERE I INDICATE THAT I UNDERSTAND THE CONTENTS OF THIS DOCUMENT AND THE EFFECT OF THIS GRANT OF POWERS TO MY AGENT. I AM OF SOUND MIND AND WILLFULLY AND VOLUNTARILY EXECUTE THIS DOCUMENT.**

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

**ACCEPTANCE OF APPOINTMENT**

The undersigned accept appointment as agents under this Last Wishes Document.

Agent: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Signature: \_\_\_\_\_ Other Phone: \_\_\_\_\_  
Address: \_\_\_\_\_

1st Substitute Agent: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Signature: \_\_\_\_\_ Other Phone: \_\_\_\_\_  
Address: \_\_\_\_\_

I sign my name to this Last Wishes Document on this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_.  
My current home address is \_\_\_\_\_

Signature: \_\_\_\_\_

**WITNESS STATEMENT**

I declare that the person who signed or acknowledged this document, \_\_\_\_\_, is personally known to me, that he/she signed or acknowledged this Last Wishes Document in my presence, and that he/she appears to be of sound mind and under no duress, fraud, or undue influence. I am not the person appointed as Agent by this document, nor am I the patient's healthcare provider or an employee of the patient's healthcare provider. I further declare that I am not related to the Principal by blood, marriage, or adoption, and to the best of my knowledge, I am not a creditor of the Principal nor entitled to any part of his or her estate under a will now existing or by operation of law.

(“MY LAST WISHES” form continues on next page)

**Witness No. 1**

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

Print Name: \_\_\_\_\_ Phone: \_\_\_\_\_

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

**Witness No. 2**

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

Print Name: \_\_\_\_\_ Phone: \_\_\_\_\_

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

**STATE OF COLORADO**

**CITY** \_\_\_\_\_ **COUNTY** \_\_\_\_\_

Subscribed and sworn to before me by \_\_\_\_\_, the  
Principal, as the voluntary act and deed of the Principal, and by \_\_\_\_\_  
and \_\_\_\_\_, as witnesses, this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

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

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

## Letter to My Doctor Concerning Decisions To Be Made at the End of My Life

Dear Dr. \_\_\_\_\_,

It is important to me to have excellent and compassionate care – to keep me healthy and alive and, at the end of my life, to alleviate my suffering and to ensure that I have a peaceful and dignified death. When there are measures to extend my life, I would like to know the chances of success and the impact on the quality of my life. If I choose not to take those measures, I ask for your continued support.

If my medical condition becomes incurable and death is the only predictable outcome, I would prefer not to suffer but rather to die in a humane and dignified manner. I would like the reassurance that:

1. If I am able to speak for myself, my wishes will be honored. If not, the requests from my healthcare representative and advance directives will be honored.
2. You will make a referral to hospice should I request it.
3. You will support me with all options for a gentle death, including providing medications that I can self-administer to help my death be as peaceful as possible.

I am not requesting that you do anything unethical while I am in your care, but the understanding of what is ethical is rapidly changing as medicine strives to become more responsive to the personal choices of dying patients.

Also, as you know, the Supreme Court has confirmed that a physician may administer or prescribe medications in such amounts as to relieve pain and suffering even though this may hasten death.

I hope you will accept this statement as a fully considered decision and an expression of my deeply held views. If you feel you would not be able to honor such requests, please let me know now, while I am able to make choices based on that knowledge.

Thank you for your consideration.

Signed: \_\_\_\_\_

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

Print Name: \_\_\_\_\_

## IMPORTANT THINGS TO DO AND REMEMBER

1. Do **not** put the originals of your signed, witnessed, and notarized advance directive and other documents in a safe deposit box or any place that would keep others from having access to them. Tell your agent and family where these vitally important papers can readily be found. (Again, in Colorado, at this time, notarization is recommended but not required.)
2. The "Last Wishes," although not strictly a legal document, should be attached as an addendum to the other documents.
3. Give photocopies of the signed originals to your agent and to your substitute agents, doctors, family, close friends, clergy and anyone else who might become involved in your healthcare. If you enter a nursing home, hospital or long-term residential-care facility, have photocopies made and placed in your medical records.
4. Be sure to talk to your agent, substitute agent (sometimes referred to as the alternate), clergy, family, and friends about your wishes concerning medical treatment. Discuss your wishes often, especially if your medical condition changes.
5. If you want to make any changes to your documents after they have been signed and witnessed, you should complete **new** documents, and gather in and destroy former documents.
6. Remember, you can always revoke one or more of your Colorado documents.
7. Should death occur at home, the county coroner, 911, or your doctor should be called, as a qualified medical professional needs to be notified to make the official pronouncement of death. If hospice is being used, they will also help with this notification. If the patient does not have the Colorado Directive regarding DNR (Do Not Resuscitate) or is not wearing the bracelet or necklace, caretakers need to be aware that the paramedics may try to resuscitate. If the patient and family have been expecting death and do not want CRP administered, it would be advisable to wait two to three hours before calling 911.
8. ***The initial choice of a funeral home to remove the body is probably the most crucial decision made at the time of death, as it can have serious financial impact.*** A family member or close friend should accompany the bereaved next of kin to the mortuary to advise and support that individual making arrangements for the service. (This information is provided by Funeral Consumer Society of Colorado, 303-759-6431.)
9. If **direct cremation** is planned, the crematory may be able to collect the body directly.
10. Family and close friends also need to be notified and asked to help the next of kin with the notification of other family, friends, close neighbors, the church, and the organizations the deceased was a member of, and help with other immediate tasks.
11. It is very important that the crucial papers and information regarding prepaid funeral policies and instructions for a service, etc., are kept where the family members can find them easily. If the deceased was receiving public assistance or was a member of the military, financial assistance may be available to help cover funeral expenses. Social Services should be notified regarding anyone receiving public assistance, and the V.A. should be contacted regarding anyone who is currently or was previously in the military.
12. It is important that someone be responsible for answering the phone, collecting mail, caring for pets; keeping track of gifts of food or flowers and noting who the donors are; and for finding someone to stay in the home during the service and having refreshments available if a reception is to be held in the home following the service.

We hope this information has been helpful to you. If you have questions you can contact either Compassion & Choices of Colorado or the national Compassion & Choices office. Contact information is below.

Compassion & Choices of Colorado  
PO Box 101824  
Denver, CO 80250  
coloradochoices.org

National Compassion & Choices  
PO Box 101810  
Denver, CO 80250  
compassionandchoices.org

info@compassionandchoices.org

## A FINAL NOTE

While Compassion & Choices' focus is on creating the public and political climate to change the restrictions that prevent us from ending our lives as we decide for ourselves, and to obtain physical assistance if necessary to accomplish that, we need also to look at "what then": What do we want done with our bodies after we are dead? The traditional way is interment, and now more and more people are choosing cremation. But some are deciding to donate their organs and their bodies to medical schools, research centers, et cetera, to extend their usefulness to society. The easiest and most direct way to do this is by signing the back of your driver's license. One can also approach a medical school individually and speak with them regarding the special arrangements you would like to make. In either case, this should be discussed with legal agents, family, and special friends.

For further information on any of the subjects covered in this booklet, there is an excellent bibliography available through the national offices of Compassion & Choices. Contact information is above.

Please also note that there is a section at the bottom of the DNR certificate (copy on page 10) concerning tissue donations.

Congratulations on taking the first step in protecting your right to freedom and choice at the end of life. These documents will help ensure that you continue to make your own healthcare decisions. They offer not only personal autonomy – they also give you and your loved ones peace of mind, knowing that your wishes are firm and clear. We'll be here when you need us! Providing advance directive documents is just one of the many services we offer. Compassion & Choices members receive, free of charge, counseling and guidance on how to complete and how to use an advance directive. Those who join at the Benefactor level or above can receive a wallet-sized CD of their advance directive, which they can carry with them at all times. Emergency personnel will find this CD tucked in with your health insurance card and it will speak for you when you cannot speak for yourself. Please contact us to learn more about this service.

Your dues and donations to Compassion & Choices assure the continuation of our programs and services. Our Client Support Program is unsurpassed in offering comprehensive service and support for individuals and families as they contemplate life's end. Our education program provides literature and speakers in communities across the nation, and our advocacy team defends your right to a peaceful death on legal and legislative fronts. Join today to enlist Compassion & Choices as your lifelong advocate.

Count on us to help you protect yourself from government intrusion into healthcare, and to protect your family from disputes over your end-of-life care. Through our national team of volunteers and top-notch legal talent, we stand ready to deliver advocacy services by telephone, at the bedside, and even in the courtroom, if necessary.

Please join us in our effort to ensure care, choice, dignity and control at life's end.

**\_\_\_\_\_ Yes! I want to join Compassion & Choices**

(Please make your check payable to Compassion & Choices)

\_\_\_\_\_ Individual (\$45) \_\_\_\_\_ Couple/Dual (\$60) \_\_\_\_\_ Benefactor (\$100)

\_\_\_\_\_ Individual Life (\$450) \_\_\_\_\_ Couple/Dual Life (\$600)

\_\_\_\_\_ I choose not to join now, but please accept my enclosed donation of

\_\_\_\_\_ \$50 \_\_\_\_\_ \$100 \_\_\_\_\_ \$150 \_\_\_\_\_ \$ other

Credit card number: \_\_\_\_\_

Expiration: \_\_\_\_\_

\_\_\_\_\_ Visa \_\_\_\_\_ Mastercard

\_\_\_\_\_ I cannot contribute right now, but please keep me on your mailing list.

Name \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Daytime phone: \_\_\_\_\_ Other phone: \_\_\_\_\_

Email: \_\_\_\_\_