ADVANCE HEALTHCARE DIRECTIVE

Approved for Use in the Catholic Diocese of Honolulu

Date ____________________

Last Name ___________________________, First ________________________ Middle ___________________

Address ____

City _________________________ State _______________ Zip _______________

I Believe …

- **Death Is a Normal Part of the Human Condition.** Death is neither to be feared and avoided at all costs, nor to be sought and directly procured:

  > "Everyone is responsible for his life before God who has given it to him. It is God who remains the sovereign Master of life. We are obliged to accept life gratefully and preserve it for his honor and the salvation of our souls. We are stewards, not owners, of the life God has entrusted to us. It is not ours to dispose of" (*Catechism of the Catholic Church*, 2280).

  Consequently, physician assisted suicide and euthanasia are wrong. (Euthanasia is defined as the intentional ending of human life by act or omission in order to relieve suffering.)

- **Pain Relief.** The use of medicine to treat acute pain is always acceptable even if, *incidentally*, it were to shorten life. Such pain control is not the same as euthanasia since death is not the objective of the treatment. Maintenance of lucidity is an important element in preparing for death, but pain should be alleviated to the extent possible.

- **Proportionality of Life-Sustaining Medical Treatment.** Decisions to administer, refuse, or discontinue life-sustaining treatment should be based on the concept of *proportionality*. That is, one does not have an obligation to pursue a life-sustaining treatment if the risks or burdens are disproportionate to its expected benefits. The concept of burden must be individually assessed; it includes aspects such as the discomfort, risk, and expense of the treatment in question.

- **Nutrition and Hydration (Food and Water).** The failure to provide a patient with nutrition and hydration *for the purpose of ending the patient's life or accelerating the patient's death* constitutes euthanasia and is wrong, even when nourishment must be provided by artificial means. However, situations can arise where the provision of nutrition and hydration no longer provides substantial benefits and is actually burdensome to a dying patient. In such cases, the provision of food and water, by artificial means or otherwise, may no longer be appropriate, even if the dying process is *incidentally* hastened.

- **Consultation with Medical and Spiritual Advisors.** It is not always easy for patients, family, or healthcare agents to apply the principles of proportionality to a particular situation. Consultation with medical advisors is almost always required in order to evaluate potential benefits, burdens, and risks. Consultation with competent spiritual advisors may help patients, family, or healthcare agents arrive at more objective decisions.

Ecclesiastical approbation given on December 6, 2018
by the Most Reverend Clarence Silva, Bishop of Honolulu.

Provide Copies To:

❑ Agent ❑ Alternate agent ❑ Family members ❑ Close friends ❑ Physicians

Effect of Copy: A copy has the same effect as the original.

Part 1 – POWER OF ATTORNEY FOR HEALTHCARE

1.1 **Primary Appointment.** I, ____, hereby designate the following individual as my agent to make healthcare decisions for me:

Print Name ____ Relationship _______________________

Address ____ City __________________ State _____ Zip ___________

Home Phone _____________________ Work Phone _______________________ Cell Phone _____________________

Email Address ____

1.2 **Alternate Agent Appointment.** If my agent is not willing, able, or reasonably available to make healthcare decisions for me, I designate as my alternate agent:

Print Name ____ Relationship _______________________

Address ____ City __________________ State _____ Zip ___________

Home Phone _____________________ Work Phone _______________________ Cell Phone _____________________

Email Address ____

1.3 **Agent's Authority.** My agent is authorized to make all healthcare decisions for me, including decisions to provide, withhold or withdraw medical treatment to keep me alive, *except as I state in Part 2 below***.** I have discussed my wishes with my agent and my agent shall make healthcare decisions for me in accordance with my best interests and wishes so far as they are known. My agent shall consider my personal values, especially those stated above. If a guardian of my person needs to be appointed for me by a court, I nominate my agent.

I also retain the right to make my own decisions about health care and can revoke my agent's authority at any time as long as I have mental capacity.

1.4 **When Agent's Authority Becomes Effective.** Check (a) or (b).

_____ (a) My agent's authority to make healthcare decisions for me takes effect immediately.

_____ (b) My agent's authority only becomes effective when my primary physician determines that I am unable to make healthcare decisions.

1.5 **HIPAA Disclosure Authorization.** By signing this Advance Healthcare Directive, I specifically empower and authorize my physician, as well as any hospital or other healthcare provider of any kind to release any and all medical records to my healthcare agent or my healthcare agent's designee. Further, I waive any liability on the part of any physician, hospital, or other healthcare provider who releases any and all of my medical records to my healthcare agent or to another person or entity pursuant to my healthcare agent's direction.

- The protected medical information to be disclosed includes my entire medical record for all dates of service.
- The purposes of use and disclosure of my protected medical information include my medical treatment as well as for legal purposes and to carry out my request that my protected medical information be disclosed to my healthcare agents.
- I understand that a reasonable fee may be charged for duplication of records and that an estimate of those charges will be provided upon request prior to duplication.
- This authorization is voluntary. I understand that healthcare providers and health plans will not condition my treatment, payment, enrollment, or eligibility for benefits on the signing of this authorization except as allowed by law.
- I understand that I may revoke this authorization by notifying healthcare providers and health plans, in writing, of my revocation. I understand that the revocation will not apply to any information that is already released or used in reliance on this authorization, and that there may be other legal restrictions on my ability to revoke this authorization. I understand that the revocation will not apply if the authorization was obtained as a condition of obtaining insurance coverage, when the law provides my insurer with the right to contest a claim under my policy or my policy itself.
- I understand that the health information released under this authorization may be re-disclosed by the recipient and may no longer be protected under applicable federal and state privacy laws and regulations.
- I release my healthcare providers and health plans from all liability and claims whatsoever pertaining to the disclosure of information contained in the records released pursuant to this authorization.
- This authorization shall be effective until two years after my death unless I revoke it in the meantime.
- I specifically authorize the release of the following information, should it be in my medical record: information concerning or relating to Acquired Immune Deficiency Syndrome (AIDS) or HIV, alcohol and/or drug abuse treatment, or behavioral or mental health services.

This authorization is effective immediately and, notwithstanding the provision of Section 1.4 above, are not contingent on my own inability to make healthcare decisions.

Part 2 – INSTRUCTIONS FOR HEALTHCARE

2.1 **Healthcare Decisions Should Be Consistent with Catholic Teaching.** I, ___________________________________, direct that any decision concerning my healthcare should be consistent with relevant teachings of the Catholic Church. Those teachings are summarized on the first page of this Advance Healthcare Directive.

2.2 **End-Of-Life Decisions.** It is impossible to adequately anticipate all the considerations which must be weighed at the time when a decision concerning life-sustaining treatment is to be made. Therefore, if I have appointed an agent in Part 1 above. I have full confidence in the judgment of that person, and I request that my healthcare providers follow his or her instructions.

2.3 **What Is Important to Me *(optional).*** The things that I value and that make life worth living (for example, attending family gatherings, going to church, seeing friends, engaging in favorite activities, hobbies, pets):

____

____

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____

____

Number of ___ Additional page(s) attached

2.4 **Specific Instructions *(optional).*** The following lines may be used to set forth any further directions, limitations, or statements concerning healthcare, treatment, services and procedures, especially in relation to prolonging my life:

____

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____

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Number of ___ Additional page(s) attached

Part 3 – ORGAN DONATION

3.1 **Donation of Organs *(optional).***

The agent designated in this document has the authority to make anatomical gifts unless contrary intentions have been expressed. In order to clearly express your intentions, check (a), (b), or (c) and use blank spaces for any limitations:

___ (a) I do not wish to donate any of my organs, tissues or parts upon my death.

___ (b) I give any needed organs, tissues, or parts.

___ (c) My gift is limited to the following organs, tissues or parts only:

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____

My gift is for the following purposes (cross out any of the following you do not want):

(1) Transplant (2) Therapy (3) Research (4) Education (5) Cosmetic

Part 4 – SIGNATURE AND WITNESSES OR NOTARY PUBLIC

All signers and agents named in this document must be 18 years of age or older.

4.1 ***Print*** Your Name in Full ____

Your Signature ____ Date __________________

Date of Birth ______________________________ Social Security Number XXX - XX - ___________

Choose either Option 1 or Option 2, not both.

4.2 **OPTION 1: Two Witnesses**

Important: Witnesses cannot be your healthcare agent, a healthcare provider or an employee of a healthcare facility. One of the witnesses cannot be a relative or have inheritance rights.

Witness 1 – ***Print*** Witness Name ____

Witness Signature ____ Date __________________

Address ____ City __________________ State _____ Zip ___________

Witness 2 – ***Print*** Witness Name ____

Witness Signature ____ Date __________________

Address ____ City __________________ State _____ Zip ___________

4.3 **OPTION 2: Notary Public**

STATE OF HAWAII)
) ss.
CITY AND COUNTY OF HONOLULU)

On _________________________, in the ______________ Circuit, State of Hawaii, before me personally appeared ____, to me personally known (or proven on the basis of satisfactory evidence) to be the individual who signed the foregoing Advance Healthcare Directive, dated ___________________________, consisting of _____ pages, and acknowledged that he/she did so as his/her free and voluntary act.

____

Name:

Notary Public, State of Hawaii

My commission expires: