

Arizona Advance Directive for Health Care Planning

An Advance Directive for Health Care or Living Will is a written statement that expresses your wishes about medical treatment that would delay death from a terminal condition. It also applies to situations of persistent vegetative state or irreversible coma. A Living Will would speak for you in the event that you were unable to communicate. It gives direction and guidance to others, but is not as broadly applicable as a Durable Health Care Power of Attorney. For example, a Living Will does not permit health care providers to stop tube feeding - only an agent appointed by a Durable Health Care Power of Attorney or a court-appointed guardian may make such a decision. You can have a Living Will and a Durable Health Care Power of Attorney but if you sign both you must attach a copy of your Living Will to the Durable Health Care Power of Attorney.

The Arizona Advance Directive Registry was created in May 2004 by the Arizona State Legislature. The Registry is a database for the storage of advance directives (Living Will, Medical Power of Attorney, and Mental Health Power of Attorney). The Arizona Secretary of State oversees Registry filings, its security, and its operations. Health care providers may use the Registry to look up registered directives using the information provided to them by the registrant or the registrant's loved ones. Further information and access to the Registry is available on the Secretary of State's Web site at www.azsos.gov or by calling 602.542.6187 or toll free 800.458.5842. Please request information at the following:

Office of the Attorney General of Arizona

Kris Mayes

2005 N Central Avenue

Phoenix, Arizona 85004

Direct Line: 602.542.5025

Toll Free: 800.352.8431

Fax: 602.364.1970

www.azag.gov

You can also get the Arizona Advanced care (Living Will) and all other POA forms online at:

https://disabilityrightsaz.org/wp-content/upload/2025/07LegalOptionsManual_2025_Accessible.pdf

Either fill out online and print or print and handwrite in the form if you don't want to type all the information into your browser.

If you do not have access to a personal computer or printer capabilities and would like a copy of the **Advance Directive for Health Care or Living Will** form ask a Panacea Brain and Spine staff associate for a printed copy.

I _____ Date _____

Acknowledge I have been given the appropriate information regarding the **Arizona Advance Directive for Health Care Planning** and the registry database storage at office of The Arizona Secretary of State.

PANACEA BRAIN AND SPINE, LLC

CHAD E. HARTLEY M.D. * MARC D. CHRISTENSEN M.D.

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HEALTH CARE POWER OF ATTORNEY Instructions and Information

GENERAL INSTRUCTIONS: Use this form if you want to select a person, called an “agent”, to make future health care decisions for you so that if you become too ill or cannot make those decisions for yourself the person you choose and trust can make medical decisions for you. Be sure you understand the importance of this document. It is a good idea to talk to your doctor and loved ones if you have questions about the type of health care you do or do not want.

AUTOPSY CHOICE: If there is no legal reason to require an autopsy, you can decide if you want one done when you die, or whether you want your agent to choose for you. There is usually a charge for voluntary autopsies. You can help your family and loved ones by making your preferences on this topic clear. For additional information on autopsies please review Arizona Revised Statutes §§ 11-591 and 11-597.

ORGAN DONATION CHOICE (OPTIONAL): You can determine if you want to donate organs or tissues, and if you do, what organs or tissues you want to donate, for what purposes, and to what organizations. You also have the option of whole-body donation for research purposes. You can also choose to have your agent decide. For additional information on Organ Donation, please review Arizona Revised Statutes §§ Title 36, Chapter 7, Article 3 for the laws that pertain to it.

FUNERAL AND BURIAL CHOICE (OPTIONAL): You can determine, your funeral and burial choices in this form. You can select if, upon your death, you would like to be buried and where, or if you would like to be cremated and where your ashes will go, or you can select your agent to make that choice.

If you fill out this form, make sure you **DO NOT SIGN UNTIL** your witness or a notary public is present to watch you sign it.

PLEASE NOTE: At least one adult witness, not to include the proxy if there is one, OR a notary public must witness you signing this document.

DO NOT have the documents signed by both a witness and a notary, just pick one. If you do not know a notary or cannot pay for one, a witness is legally accepted.

Witnesses or notary public CANNOT be anyone who is:

- (a) under the age of 18
- (b) related to you by blood, adoption, or marriage
- (c) entitled to any part of your estate
- (d) appointed as your agent
- (e) involved in providing your health care at the time this form is signed

OFFICE OF THE ARIZONA ATTORNEY GENERAL
KRIS MAYES

Health Care Power of Attorney

My Information (I am the "Principal"):

Name: _____

Date of Birth: _____

Address: _____

Phone: _____

Email: _____

Selection of my health care power of attorney and alternate:

I choose the following person to act as my agent to make health care decisions for me:

Name: _____

Home Phone: _____

Address: _____

Work Phone: _____

Cell Phone: _____

I choose the following person to act as an alternate to make health care decisions for me if my first agent is unavailable, unwilling, or unable to make decisions for me:

Name: _____

Home Phone: _____

Address: _____

Work Phone: _____

Cell Phone: _____

I AUTHORIZE my agent to make health care decisions for me when I cannot make or communicate my own health care decisions. I want my agent to make all such decisions for me except any decisions that I have expressly stated in this form that I do not authorize him/her to make. My agent should explain to me any choices he or she made if I am able to understand. I further authorize my agent to have access to my "personal protected health care information and medical records". This appointment is effective unless it is revoked by me or by a court order.

Health care decisions that I expressly DO NOT AUTHORIZE if I am unable to make decisions for myself: (Explain or write in "None")

My specific wishes regarding autopsy (additional information on page 1):

*Please note that if not required by law a voluntary autopsy may cost money. Initial your choice.

_____: Upon my death I DO NOT consent to a voluntary autopsy.

_____: Upon my death I DO consent to a voluntary autopsy.

_____: My agent may give or refuse consent for an autopsy.

My specific wishes regarding organ donation (additional information on page 1):

If you do not initial this section your agent may make these decisions for you. Initial your choice.

_____: I DO NOT WANT to make an organ or tissue donation, and I DO NOT want this donation authorized on my behalf by my agent or my family.

_____: I have already signed a written agreement or donor card regarding donation with the following individual or institution: _____

_____: I DO WANT to make an organ or tissue donation when I die. Here are my directions:

1. What organs/tissues I choose to donate (initial below):

- a. _____: Whole body
- b. _____: Any needed parts or organs
- c. _____: These parts or organs only:
 - i. _____

2. I am donating organs/tissue for (initial below):

- a. _____: Any legally authorized purpose
- b. _____: Transplant or therapeutic purposes only
- c. _____: Research only
- d. _____: Other: _____

3. The organization or person I want my organs/tissue to go to are (initial below):

- a. _____: _____
- b. _____: Any that my agent chooses

My specific wishes regarding funeral and burial disposition (additional information on page 1):

_____: Upon my death, I direct my body to be buried. (Instead of cremated)

_____: Upon my death, I direct my body to be buried in: _____

_____: Upon my death, I direct my body to be cremated.

_____: Upon my death, I direct my body to be cremated with my ashes to be _____

_____: My agent will make all funeral and burial decisions.

Do you have a living will?

If you have a Living Will, **you must attach** the Living Will to this form. A blank Living Will is available on the Attorney General’s website www.azag.gov. Initial below.

_____: I have SIGNED AND ATTACHED a completed Living Will to this Health Care Power of Attorney.

_____: I have NOT SIGNED a Living Will.

Do you have a POLST (Portable Medical Order)?

A **POLST** form is for when you become seriously ill or frail and toward the end of life. A blank POLST is available on the Attorney General’s website www.azag.gov. Initial below.

_____: I have SIGNED AND ATTACHED a completed POLST to this Health Care Power of Attorney.

_____: I have NOT SIGNED a POLST.

Do you have a Prehospital Medical Care Directive – a type of Do Not Resuscitate form (DNR)?

A blank Prehospital Medical Care Directive or DNR is available on the Attorney General’s website www.azag.gov. Initial below.

_____: I and my doctor or health care provider HAVE SIGNED a Prehospital Medical Care Directive or DNR on Paper with ORANGE background in the event that Emergency Medical Technicians or hospital emergency personnel are called and my heart or breathing has stopped.

_____: I have NOT SIGNED a Prehospital Medical Care Directive or DNR.

PHYSICIAN AFFIDAVIT (OPTIONAL)

You may wish to ask questions of your physician regarding a particular treatment or about the options in the form. If you do speak with your physician it is a good idea to ask your physician to complete this affidavit and keep a copy for his/her file.

I, Dr. _____ have reviewed this document and have discussed with _____ any questions regarding the probable medical consequences of the treatment choices provided above. This discussion with the principal occurred on this day _____.

I have agreed to comply with the provisions of this directive.

Signature of Physician

HIPAA WAIVER OF CONFIDENTIALITY FOR MY AGENT

_____ (Initial) I intend for my agent 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. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (aka HIPAA), 42 USC 1320d and 45 CFR 160-164.

Revocability of this Health Care Power of Attorney: I retain the right to revoke all or any portion of this form or to disqualify any agent designated by me in this document.

MY SIGNATURE VERIFICATION FOR THE HEALTH CARE POWER OF ATTORNEY

My Signature (Principal): _____ Date: _____

If you are unable to physically sign this document, your witness/notary may sign and initial for you. If applicable have your witness/notary sign below.

Witness/Notary Verification: The principal of this document directly indicated to me that this Health Care Power of Attorney expresses their wishes and that they intend to adopt it at this time.

Witness/Notary Signature: _____

Name Printed: _____ Date: _____

SIGNATURE OF WITNESS (See Page 1 for who CANNOT be a witness)

I was present when this form was signed (or marked). The principal appeared to be of sound mind and was not forced to sign this form. I affirm that I meet the requirements to be a witness as indicated on page one of the health care power of attorney form.

Witness Signature: _____ Date: _____

Name Printed: _____

Address: _____

OR

SIGNATURE OF NOTARY (See Page 1 for who CANNOT be a Notary)

Notary Public (NOTE: If a witness signs your form, you SHOULD NOT have a notary sign):

NOTORIAL JURAT: Pertains to all five pages of this Health Care Power of Attorney

Dated _____, 20_____.

STATE OF ARIZONA) ss

COUNTY OF _____)

Principal's Name

Subscribed and sworn (or affirmed) before me this _____ day of _____, 20_____

Notary Public Signature: _____

My Commission Expires: _____



LIVING WILL (End of Life Care) Instructions

GENERAL INSTRUCTIONS: Use this form to make decisions now about your medical care if you are ever in a terminal condition, a persistent vegetative state or an irreversible coma. You should talk to your doctor about what these terms mean.

The Living Will is your written directions to your health care power of attorney, also referred to as your "agent", your family, your physician, and any other person who might make medical care decisions for you if you are unable to communicate yourself.

It is a good idea to talk to your doctor and loved ones if you have questions about the type of care you do or do not want.

IMPORTANT: If you have a Living Will and a Health Care Power of Attorney, you must attach the Living Will to the Health Care Power of Attorney.

If you fill out this form, make sure you **DO NOT SIGN UNTIL** your witness or a notary public is present to watch you sign it.

PLEASE NOTE: At least one adult witness, not to include the proxy if there is one, OR a notary public must witness you signing this document.

DO NOT have the documents signed by both a witness and a notary, just pick one. If you do not know a notary or cannot pay for one a witness is legally accepted.

Witnesses or notary public CANNOT be anyone who is:

- (a) under the age of 18
- (b) related to you by blood, adoption, or marriage
- (c) entitled to any part of your estate
- (d) appointed as your agent
- (e) involved in providing your health care at the time this form is signed

OFFICE OF THE ARIZONA ATTORNEY GENERAL
KRIS MAYES

Living Will

My Information (I am the "Principal"):

Name: _____

Date of Birth: _____

Address: _____

Phone: _____

Email: _____

Some general statements about your health care choices are listed below. If you agree with one of the statements, you should initial that statement. Read all of these statements carefully BEFORE you initial your preferred statement. You can also write your own statement concerning life-sustaining treatment and other matters relating to your health care. You may initial any combination of paragraphs 1, 2, 3 and 4, BUT if you initial paragraph 5 the others should not be initialed.

_____ 1. If I have a terminal condition I do not want my life to be prolonged, and I do not want life-sustaining treatment, beyond comfort care, that would serve only to artificially delay the moment of my death.

***Comfort care is treatment given in an attempt to protect and enhance the quality of life without artificially prolonging life.*

_____ 2. If I am in a terminal condition or an irreversible coma or a persistent vegetative state that my doctors reasonably feel to be irreversible or incurable, I do want the medical treatment necessary to provide care that would keep me comfortable, but I DO NOT want the following:

_____ a. Cardiopulmonary resuscitation (CPR). For example: the use of drugs, electric shock and artificial breathing.

_____ b. Artificially administered food and fluids.

_____ c. To be taken to a hospital if at all avoidable.

_____ 3. Regardless of any other directions I have given in this Living Will, if I am known to be pregnant, I do not want life-sustaining treatment withheld or withdrawn if it is possible that the embryo/fetus will develop to the point of live birth with the continued application of life-sustaining treatment.

_____ 4. Regardless of any other directions I have given in this Living Will, I do want the use of all medical care necessary to treat my condition until my doctors reasonably conclude that my condition is terminal or is irreversible and incurable or I am in a persistent vegetative state.

_____ 5. I want my life to be prolonged to the greatest extent possible (If you initial here, you should not initial any of the others).

PLEASE NOTE: You can attach additional instructions on your medical care wishes that have not been included in this Living Will form. Initial or put a check mark by box A or B below. Be sure to include the attachment if you check B.

_____ A. I HAVE NOT attached additional special instructions about End of Life Care I want.

_____ B. I HAVE attached additional special provisions or limitations about End of Life Care I want.

MY SIGNATURE VERIFICATION FOR THE LIVING WILL

My Signature (Principal): _____ Date: _____

If you are unable to physically sign this document your witness/notary may sign and initial for you. If applicable, have your witness/notary sign below.

Witness/Notary Verification: The principal of this document directly indicated to me that this Living Will expresses their wishes and that they intend to adopt it at this time.

Witness/Notary Signature: _____

Name Printed: _____ Date: _____

SIGNATURE OF WITNESS

I was present when this form was signed (or marked). The principal appeared to be of sound mind and was not forced to sign this form.

Witness Signature: _____ Date: _____

Name Printed: _____

Address: _____

OR

SIGNATURE OF NOTARY

Notary Public (NOTE: If a witness signs your form, you SHOULD NOT have a notary sign):

NOTORIAL JURAT: Pertains to all three pages of this Living Will

Dated _____, 20____.

STATE OF ARIZONA) ss

COUNTY OF _____)

Principals Name

Subscribed and sworn (or affirmed) before me this _____ day of _____, 20 _____

Notary Public Signature: _____

My Commission Expires: _____