

IMPORTANT

**PLEASE READ THIS BEFORE COMPLETING YOUR
ADVANCE DIRECTIVE**

- ❖ An advance directive is a legal document through which you may provide directions as to your medical care. It is used when you are unable to make or communicate your decisions about your medical treatment. It is prepared before any condition or circumstance occurs that causes you to be unable to actively make a decision about your medical care.
- ❖ In Connecticut, judges and hearing officers have the power to override the treatment choices of some competent people and may therefore be able to override the choices you make, including medication choices.
- ❖ This advance directive form has been created to meet many of the health care needs of people who are receiving mental health services. Although this form has been created for people receiving mental health services, anyone can use it.
- ❖ This advance directive for health care is meant to help you plan for the future. It is not meant to give legal advice. It does not try to answer all questions about anything that could come up. Every person is different, and every situation is different. Laws change from time to time. If you have a specific question or problem, talk to a medical or legal professional for advice.
- ❖ Assistance is available to help you understand and complete this form. You can have your questions answered by a trained advocate. Agencies available to provide assistance are listed on the back cover of this Toolkit. We encourage you to seek assistance.

This is the ADVANCE DIRECTIVE of:

▣ Name: _____

Address: _____

Telephone Numbers: _____

e-mail Address: _____

▣ My Health Care Representative is:

Address: _____

Telephone Numbers: _____

▣ My Alternate Health Care Representative is:

Address: _____

Telephone Numbers: _____

My Advance Directive for Health Care

On this date, _____, I am taking the following medications:

Medication Name:

Medication Dosage:

1. _____	1. _____
2. _____	2. _____
3. _____	3. _____
4. _____	4. _____
5. _____	5. _____
6. _____	6. _____
7. _____	7. _____
8. _____	8. _____
9. _____	9. _____
10. _____	10. _____

My current doctors are:

Dr. _____ Phone # _____

Address: _____

Type of Practice: _____

Dr. _____ Phone # _____

Address: _____

Type of Practice: _____

Dr. _____ Phone # _____

Address: _____

Type of Practice: _____

Allergies and other medical information you should know:

Important: Information in this section cannot be changed after the document has been signed, witnessed, and notarized.

To any physician treating me . . .

This document contains the following:

- APPOINTMENT OF A HEALTH CARE REPRESENTATIVE;
- THE DESIGNATION OF MY CONSERVATOR OF THE PERSON AND ESTATE FOR MY FUTURE INCAPACITY;
- DOCUMENT OF ANATOMICAL GIFT; AND
- HEALTH CARE INSTRUCTIONS.

These are my health care instructions including those concerning the withholding or withdrawal of life support systems, together with the appointment of my health care representative, the designation of my conservator of the person and estate for future incapacity and my document of anatomical gift. As my physician, you may rely on these health care instructions and any decision made by my health care representative or conservator of my person, if I am incapacitated to the point when I can no longer actively take part in decisions for my own life, and am unable to direct my physician as to my own medical care.

My Advance Directive for Health Care

▣ APPOINTMENT OF HEALTH CARE REPRESENTATIVE:

I understand that, as a competent adult, I have the right to make decisions about my health care. There may come a time when I am unable, due to incapacity, to make my own health care decisions. In these circumstances, those caring for me will need direction and will turn to someone who knows my values and health care wishes. By signing this appointment of health care representative, I appoint a health care representative with legal authority to make health care decisions on my behalf in such case or at such time.

I appoint _____ to be my health care representative.

_____ *I do not have a Health Care Representative. However, I want this document to serve as a legal testament of my wishes. (Initial)*

If my attending physician determines that I am not able to understand and appreciate the nature and consequences of health care decisions and unable to reach and communicate an informed decision regarding treatment, my health care representative is authorized to:

Make any and all health care decisions for me, including the decision to accept or refuse any treatment, service or procedure used to diagnose or treat my physical condition, except as otherwise provided by law, including, but not limited to, psychosurgery or shock therapy, and the decision to provide, withhold or withdraw life support systems. I direct my health care representative to make decisions on my behalf in accordance with my wishes, as stated in this document or as otherwise know to my health care representative. In the event my wishes are not clear or a situation arises that I did not anticipate, my health care representative may make a decision in my best interests, based upon what is known of my wishes.

▣ APPOINTMENT OF ALTERNATE HEALTH CARE REPRESENTATIVE:

If _____ is unwilling or unable to serve as my health care representative, I appoint _____ to be my alternate health care representative.

_____ *I do not have an Alternate Health Care Representative. (Initial)*

RELEASE OF MEDICAL INFORMATION:

I, _____, give permission to any health care, residential care, or nursing home facility that is providing me treatment to disclose and/or provide any information he/she/it possesses or controls, including personal observations or written records to my Health Care Representative: _____.

This release is to take effect regardless of my capacity and regardless of whether or not my advance directive is in effect. This release is intended to include regarding:

(Initial all that apply.)

_____ Alcohol and/or drug treatment

_____ Mental health treatment

_____ HIV status

The information and/or records to be released pertain to and may include any and all records and/or information regarding me that is in the possession or control of the facility or provider of services, its staff and/or agents.

This release shall remain effective so long as the attached advance directive is in effect.

Signature: _____ Date: _____

_____ *I do not have a Health Care Representative. (Initial)*

RELEASE OF MEDICAL INFORMATION:

I, _____, give permission to any health care, residential care, or nursing home facility that is providing me treatment to disclose and/or provide any information he/she/it possesses or controls, including personal observations or written records to my Alternate Health Care Representative: _____.

This release is to take effect regardless of my capacity and regardless of whether or not my advance directive is in effect. This release is intended to include regarding:

(Initial all that apply.)

_____ Alcohol and/or drug treatment

_____ Mental health treatment

_____ HIV status

The information and/or records to be released pertain to and may include any and all records and/or information regarding me that is in the possession or control of the facility or provider of services, its staff and/or agents.

This release shall remain effective so long as the attached advance directive is in effect.

Signature: _____ Date: _____

_____ *I do not have an Alternate Health Care Representative.*

My Advance Directive for Health Care

Conservators are appointed by the Probate Court, but you can express your preferences here. According to statute, except as authorized by a court of competent jurisdiction, a conservator shall comply with a ward's individual health care instructions and other wishes, if any, expressed while the ward had capacity and to the extent known to the conservator, and the conservator may not revoke the ward's advance health care directive unless the appointing court expressly so authorizes.

▣ DESIGNATION OF CONSERVATOR OF PERSON, IF NEEDED:

If a conservator of person should need to be appointed, I designate

_____ be appointed my conservator.

_____ *I do not have a preference for Conservator of Person. (Initial)*

▣ DESIGNATION OF ALTERNATE CONSERVATOR OF PERSON:

If my first preference is unwilling or unable to serve as my conservator of person, I designate _____ be appointed my conservator.

_____ *I do not have a preference for Alternate Conservator of Person. (Initial)*

▣ DESIGNATION OF CONSERVATOR OF ESTATE, IF NEEDED:

If a conservator of estate should need to be appointed, I designate

_____ be appointed my conservator.

_____ *I do not have a preference for Conservator of Estate. (Initial)*

▣ DESIGNATION OF ALTERNATE CONSERVATOR OF ESTATE:

If my first preference is unwilling or unable to serve as my conservator of estate, I designate _____ to be appointed my conservator.

_____ *I do not have a preference for Alternate Conservator of Estate. (Initial)*

No bond shall be required of any proposed conservator in any jurisdiction.

INITIALS: PRINCIPAL _____ WITNESS 1 _____ WITNESS 2 _____

My Advance Directive for Health Care

▣ STATEMENT OF ANATOMICAL GIFT:

I hereby make this anatomical gift, if medically acceptable, to take effect upon my death.

I give: *(Initial One)*

_____ Any needed organs or parts.

_____ Only the following organs or parts: _____

To be donated for: *(Initial One)*

_____ Any of the purposes stated in subsection (a) of the section 19a-279f of the general statutes, including education, research, and transplantation and therapy.

_____ These limited purposes: _____

Or:

_____ *I do not want to make an anatomical gift. (Initial)*

_____ *I do not want to make a decision at this time. (Initial)*

▣ OTHER SPECIFIC REQUESTS:

_____ *I have no comments. (Initial)*

My Advance Directive for Health Care

▣ MY WISHES REGARDING LIFE SUPPORT:

If the time comes when I am incapacitated to the point when I can no longer actively take part in decisions for my own life, and am unable to direct my physician as to my own medical care, I wish this statement to stand as a testament of my wishes.

(Initial **one** of the statements below)

_____ I want all measures taken to keep me alive.

_____ I've made decisions regarding the termination of life support in a separate Living Will.

_____ I request that, if my condition is deemed terminal or if it is determined that I will be permanently unconscious, I be allowed to die and not be kept alive through life support systems. By terminal condition, I mean that I have an incurable or irreversible medical condition which, without the administration of life support systems, will, in the opinion of my attending physician, result in death within a relatively short time. By permanently unconscious I mean that I am in a permanent coma or persistent vegetative state which is an irreversible condition in which I am at no time aware of myself or the environment and show no behavioral response to the environment. I do not intend any direct taking of my life, but only that my dying not be unreasonably prolonged. This request is made, after careful reflection, while I am of sound mind.

The life support systems which I do not want include, but are not limited to:
(initial any that apply)

_____ Artificial respiration

_____ Cardiopulmonary resuscitation

_____ Artificial means of providing nutrition and hydration

_____ I do not want to make a decision at this time regarding the termination of life support and I understand that extreme measures may be taken to keep me alive.

Important: Information in this section cannot be changed after the document has been signed, witnessed, and notarized.

HEALTH CARE INSTRUCTIONS

Any person eighteen years of age or older may execute a document that contains directions as to any aspect of health care. If I've appointed a health care representative, my health care representative is authorized to accept or refuse any treatment, services or procedure used to diagnose or treat my physical or mental condition, except as otherwise provided by law, including, but not limited to, psychosurgery or shock therapy, and the decision to provide, withhold or withdraw life support systems. I direct my health care representative to make decisions on my behalf in accordance with my wishes as stated, or as otherwise known to my health care representative. In the event my wishes are not clear or a situation arises that I did not anticipate, my health care representative may make a decision in my best interests, based upon what is known of my wishes.

My Advance Directive for Health Care

▣ HOSPITALS OR PROGRAMS/FACILITIES WHERE I PREFER TO BE ADMITTED:

Facility's Name: _____

Reason (optional): _____

Facility's Name: _____

Reason (optional): _____

Facility's Name: _____

Reason (optional): _____

Facility's Name: _____

Reason (optional): _____

Facility's Name: _____

Reason (optional): _____

_____ *I do not have a preference. (Initial)*

▣ HOSPITALS OR PROGRAMS/FACILITIES WHERE I PREFER NOT TO BE ADMITTED:

Facility's Name: _____

Reason (optional): _____

Facility's Name: _____

Reason (optional): _____

Facility's Name: _____

Reason (optional): _____

_____ *I do not have a preference. (Initial)*

My Advance Directive for Health Care

▣ **PHYSICIAN(S) I PREFER TO TREAT ME IF I AM HOSPITALIZED:**

Dr. _____ Phone # _____

Address: _____

Type of Practice: _____

Dr. _____ Phone # _____

Address: _____

Type of Practice: _____

Dr. _____ Phone # _____

Address: _____

Type of Practice: _____

Dr. _____ Phone # _____

Address: _____

Type of Practice: _____

Dr. _____ Phone # _____

Address: _____

Type of Practice: _____

Dr. _____ Phone # _____

Address: _____

Type of Practice: _____

_____ *I do not have a preference. (Initial)*

▣ **PHYSICIAN(S) I PREFER NOT TREAT ME:**

Dr. _____ Phone # _____

Reason: (optional) _____

Dr. _____ Phone # _____

Reason: (optional) _____

Dr. _____ Phone # _____

Reason: (optional) _____

Dr. _____ Phone # _____

Reason: (optional) _____

_____ *I do not have a preference. (Initial)*

My Advance Directive for Health Care

▣ **MEDICATIONS I PREFER FOR HEALTH CARE TREATMENT:**

My medication preferences are:

Medication Preference	Dosage Range Preference
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____
7. _____	_____
8. _____	_____
9. _____	_____
10. _____	_____

_____ *I do not have a preference. (Initial)*

▣ **MEDICATIONS I DON'T WANT:** I specifically do not want and do not want my Health Care Representative to consent to the administration of the following medications or their respective brand-name, trade-name, or generic equivalents:

Name of drug: _____

Reason: (optional) _____

Name of drug: _____

Reason: (optional) _____

Name of drug: _____

Reason: (optional) _____

Name of drug: _____

Reason: (optional) _____

_____ *I do not have a preference. (Initial)*

▣ **OTHER COMMENTS REGARDING MEDICATION:**

_____ *I have no comments. (Initial)*

My Advance Directive for Health Care

In Connecticut, a person who cannot give informed consent can only receive ECT (electroconvulsive therapy or shock treatment) if a Probate Court orders it. You can express your preferences here, but they are not binding in Court.

▣ ELECTROSHOCK TREATMENT: (electroconvulsive therapy or ECT)

My preference regarding the administration of ECT is: (Initial one of the four statements.)

_____ If recommended, I have no objection to the administration of ECT
(electroconvulsive treatment) of the following type:

_____ If recommended, I prefer the number of treatments to be: (initial one)

_____ determined by my attending physician.

_____ approved by: _____

_____ as follows: _____

Reason: (optional) _____

_____ I *do not want* the administration of ECT (electroconvulsive therapy or
electroshock therapy).

Reason: (optional) _____

_____ I *do not have a preference*.

▣ APPROACHES THAT HELP WHEN I'M HAVING A HARD TIME:

If I'm having a hard time, the following approaches have been helpful to me in the past. I would like the staff to try to use these approaches with me in the order that I have listed: (You can put a 1, 2, 3, etc., on the approaches to designate an order or check any approaches that are helpful.)

_____ Time out in my room

_____ Listening to music

_____ Arts and crafts

_____ Reading

_____ Taking a shower

_____ Watching TV

_____ Talking with a peer

_____ Pacing the halls

_____ Having my hand held

_____ Calling a friend

_____ Going for a walk

_____ Calling my therapist

_____ Punching a pillow

_____ Pounding some clay

_____ Writing in my journal

_____ Lying down

_____ Deep breathing exercises

_____ Sitting by staff

_____ Talking with staff

_____ Exercising

_____ Offer me a cigarette

_____ Offer me medication

_____ Other: _____

_____ Other: _____

_____ I *do not have a preference*. (Initial)

My Advance Directive for Health Care

▣ PEOPLE WHO ARE HELPFUL TO ME WHEN I'M UPSET:

Please assist me in contacting the following people:

Name: _____ Phone #: _____

Address: _____

Name: _____ Phone #: _____

Address: _____

Name: _____ Phone #: _____

Address: _____

_____ *I do not have a preference. (Initial)*

▣ PHYSICAL CONTACT BY STAFF:

I've found the following type of contact helpful: (holding my hand, touching my shoulder, etc.)

_____ *I do not have a preference. (Initial)*

▣ THINGS THAT MAKE IT MORE DIFFICULT WHEN I'M ALREADY UPSET:

(Check all that apply)

_____ Being touched

_____ Being isolated

_____ Bedroom door open

_____ People in uniform

_____ Time of year _____

_____ Time of day _____

_____ Yelling

_____ Loud noise

_____ Not having control/input with _____

_____ Other: _____

_____ Other: _____

_____ *I do not have a preference. (Initial)*

My Advance Directive for Health Care

The medication(s) listed in the "Emergency Involuntary Treatments" section are choices for emergency situations. I do not want these medication(s) for non-emergency treatment unless specified in the "medications I Prefer for Health Care treatment" section.

▣ EMERGENCY INVOLUNTARY TREATMENTS:

State and federal laws prohibit the use of restraint and seclusion except when it is to prevent imminent physical injury to the patient or others and other measures have failed. If it is determined that the facility can perform an emergency involuntary procedure on me (e.g., seclusion and/or physical restraint and/or medication), my wishes regarding emergency interventions are as follows: (Give 1 to your first choice, 2 to your second, and so on until your preferences have a number.)

- Seclusion
 Physical restraints
 Medication by injection: _____
 Medication in pill form: _____
 Liquid medication: _____
 Other: _____
 Other: _____
 I do not have a preference. (Initial)

▣ IN THE PAST, I'VE FOUND THE FOLLOWING HELPFUL DURING A RESTRAINT:

I have no comments. (Initial)

▣ DURING SECLUSION AND/OR RESTRAINT, I PREFER TO BE CHECKED BY:

- Female staff
 Male staff
Reason for choice: (optional) _____

I do not have a preference. (Initial)

My Advance Directive for Health Care

▣ CONSENT FOR STUDENT EDUCATION, TREATMENT STUDIES, OR DRUG TRIALS:

_____ I authorize my Health Care Representative to consent to my participation in:

_____ Student education

_____ Treatment studies

My Health Care Representative will consult with my treating physician, and any other individuals my Health Care Representative may think appropriate, determine that the potential benefits to me outweigh the possible risks of my participation and that other, non-experimental interventions are not likely to provide effective treatment. This consent is not intended to substitute for any other consent required by law.

_____ I do not wish to participate in student education, treatment studies, or drug trials.

_____ *I do not have a preference.*

▣ PEOPLE I WANT IMMEDIATELY NOTIFIED IF I AM ADMITTED TO A HEALTH CARE FACILITY:

If I am unable to do so myself, I want my Health Care Representative to contact the following people:

Name: _____ Relationship: _____

Address: _____

Phone #'s: _____

It is also my desire that this person be permitted to visit me: _____ Yes _____ No

Name: _____ Relationship: _____

Address: _____

Phone #'s: _____

It is also my desire that this person be permitted to visit me: _____ Yes _____ No

Name: _____ Relationship: _____

Address: _____

Phone #'s: _____

It is also my desire that this person be permitted to visit me: _____ Yes _____ No

_____ *I do not have a preference. (Initial)*

SIGNATURE PAGES:

My Advance Directive for Health Care

▣ SIGNATURE OF THE PRINCIPAL:

These requests, appointments, and designations are made after careful reflection, while I am of sound mind. Any party receiving a duly executed copy or facsimile of this document may rely upon it unless such party has received actual notice of my revocation of it.

Signature of Principal

Date

▣ SIGNATURE OF THE WITNESSES: (If residing in a DMHAS or DMR facility, use next section.)

We, the subscribing witnesses, being duly sworn, say that we witnessed the execution of these health care instructions, the appointment of a health care representative, the designation of a conservator for future incapacity and a document of anatomical gift by the author of this document; that the author subscribed, published and declared the same to be the author's instructions, appointments and designation in our presence; that we thereafter subscribed the document as witnesses in the author's presence, at the author's request, and in the presence of each other; that at the time of the execution of said document the author appeared to us to be eighteen years of age or older, of sound mind, able to understand the nature and consequences of said document, and under no improper influence, and we make this affidavit at the author's request this _____ day of _____, 20 _____.

Witness (Signature)

Witness (Signature)

Witness (Print Name)

Witness (Print Name)

Street Address

Street Address

City, State and Zip Code

City, State and Zip Code

▣ SIGNATURE OF NOTARY:

On this the _____ day of _____, 20 _____, the following individuals personally appeared (Principal) _____, (Witnesses) _____ and _____ known to me (or satisfactorily proven) to be the persons whose names are subscribed, sworn, and acknowledged.

Commissioner of the Superior Court/Notary Public
My Commission expires: _____

My Advance Directive for Health Care

IF YOU ARE CURRENTLY RESIDING IN A DMHAS OR DMR FACILITY:

DMHAS: For persons who reside in facilities operated or licensed by the Department of Mental Health and Addictions Services, at least one witness shall be an individual who is not affiliated with the facility and at least one witness shall be a physician or clinical psychologist with specialized training in treating mental illness.

DMR: For persons who reside in facilities operated or licensed by the Department of Mental Retardation, at least one witness shall be an individual who is not affiliated with the facility and at least one witness shall be a physician or clinical psychologist with specialized training in developmental disabilities.

▣ SIGNATURE OF THE WITNESSES IF PRINCIPAL IS CURRENTLY RESIDING IN DMHAS OR DMR FACILITY:

We, the subscribing witnesses, being duly sworn, say that we witnessed the execution of these health care instructions, the appointment of a health care representative, the designation of a conservator for future incapacity and a document of anatomical gift by the author of this document; that the author subscribed, published and declared the same to be the author's instructions, appointments and designation in our presence; that we thereafter subscribed the document as witnesses in the author's presence, at the author's request, and in the presence of each other; that at the time of the execution of said document the author appeared to us to be eighteen years of age or older, of sound mind, able to understand the nature and consequences of said document, and under no improper influence, and we make this affidavit at the author's request this _____ day of _____, 20 _____.

Witness (Signature)

Witness (Signature, Physician or Clinical Psychologist)

Witness (Printed Name)

Witness (Print Name, Physician or Clinical Psychologist)

Street Address

Street Address

City, State and Zip Code

City, State and Zip Code

Name of Psychiatrist or Psychologist: _____

Connecticut License Number: _____

Agency Name: _____

▣ SIGNATURE OF NOTARY:

On this the _____ day of _____, 20 _____, the following individuals personally appeared (Principal) _____, (Witnesses) _____ and _____ known to me (or satisfactorily proven) to be the persons whose names are subscribed, sworn, and acknowledged.

Commissioner of the Superior Court/Notary Public

My Commission expires: _____

OPTIONAL PROVISIONS:

My Advance Directive for Health Care

HEALTH CARE REPRESENTATIVE ACCEPTANCE: (can be helpful)

I hereby accept the designation of Health Care Representative.

Health Care Representative

Date

Contact Information:

Address: _____

Telephone Numbers: _____

ALTERNATE HEALTH CARE REPRESENTATIVE ACCEPTANCE: (can be helpful)

I hereby accept the designation of Alternate Health Care Representative.

Alternate Health Care Representative

Date

Contact Information:

Address: _____

Telephone Numbers: _____

CONSERVATOR OF PERSON ACCEPTANCE: (can be helpful)

I hereby accept the designation of Conservator of Person.

Health Care Representative

Date

Contact Information:

Address: _____

Telephone Numbers: _____

ALTERNATE CONSERVATOR OF PERSON ACCEPTANCE: (can be helpful)

I hereby accept the designation of Alternate Health Care Representative.

Alternate Health Care Representative

Date

Contact Information:

Address: _____

Telephone Numbers: _____

My Advance Directive for Health Care

CONSERVATOR OF ESTATE ACCEPTANCE: (can be helpful)

I hereby accept the designation of Conservator of Person.

Health Care Representative

Date

Contact Information:

Address: _____

Telephone Numbers: _____

ALTERNATE CONSERVATOR OF ESTATE ACCEPTANCE: (can be helpful)

I hereby accept the designation of Alternate Health Care Representative.

Alternate Health Care Representative

Date

Contact Information:

Address: _____

Telephone Numbers: _____

I AM RESPONSIBLE FOR THE CARE FOR MY CHILD(REN); PLEASE CONTACT THE FOLLOWING PERSON TO PROVIDE CHILDCARE:

Name: _____ Relationship: _____

Address: _____

Phone #'s: _____

If the person named above is unavailable, please contact:

Name: _____ Relationship: _____

Address: _____

Phone #'s: _____

Additional information regarding my child(ren): _____

My Advance Directive for Health Care

▣ I AM RESPONSIBLE FOR THE CARE OF MY PET(S); PLEASE CONTACT THE FOLLOWING PERSON TO PROVIDE PETCARE:

Name: _____ Relationship: _____

Address: _____

Phone #'s: _____

If the person named above is unavailable, please contact:

Name: _____ Relationship: _____

Address: _____

Phone #'s: _____

Additional information regarding my pet(s): _____

▣ I HAVE THE FOLLOWING ADDITIONAL RESPONSIBILITIES:

Responsibility: _____

Please contact the following person about this responsibility:

Name: _____ Relationship: _____

Address: _____

Phone #'s: _____

If the person named above is unavailable, please contact:

Name: _____ Relationship: _____

Address: _____

Phone #'s: _____

Additional information regarding my responsibility: _____

My Advance Directive for Health Care

▣ LOCATION OF THIS DOCUMENT:

The original of this document will be kept by: _____
at: _____

The following persons and/or facilities will have a copy:

Name or facility: _____ Phone #: _____

Address: _____

Name or facility: _____ Phone #: _____

Address: _____

Name or facility: _____ Phone #: _____

Address: _____

Name or facility: _____ Phone #: _____

Address: _____

Name or facility: _____ Phone #: _____

Address: _____

Name or facility: _____ Phone #: _____

Address: _____

Name or facility: _____ Phone #: _____

Address: _____

Name or facility: _____ Phone #: _____

Address: _____

Name or facility: _____ Phone #: _____

Address: _____

▣ LOCATION OF OTHER IMPORTANT DOCUMENTS:

Name of document: _____

Location: _____

Name of document: _____

Location: _____

Name of document: _____

Location: _____

My Advance Directive for Health Care

▣ STATEMENT OF PATIENT ADVOCATE, HOSPITAL REPRESENTATIVE, OR AUTHORIZED PERSON:

If you are given assistance from an employee of a health care facility when completing this document, ask the person giving you assistance to complete the following information.

I personally explained the nature and effect of this Advance Directive.

Signature: _____ Printed name: _____

Title: _____ Date: _____

Facility: _____ Location: _____

▣ ENFORCEMENT:

I, _____, grant my Health Care Representative permission to contact the Office of Protection and Advocacy, CT Legal Rights Project, Inc., and/or any other attorney the authority to enforce compliance with implementation of my advance directive.

Signature: _____ Date: _____

▣ IF MY SPOUSE IS MY HEALTH CARE REPRESENTATIVE:

If your spouse is designated as your Health Care Representative, the appointment will be revoked upon legal separation, divorce, or annulment unless you complete this section.

I, _____, desire the person I have named as my Health Care Representative, who is now my spouse, to remain my Health Care Representative even if we become legally separated or our marriage is dissolved.

Signature: _____ Date: _____

RELEASE OF MEDICAL INFORMATION:

I, _____, give permission to any health care, residential care, or nursing home facility that is providing me treatment to disclose and/or provide any information he/she/it possesses or controls, including personal observations or written records to:

CT LEGAL RIGHTS PROJECT, INC.

This release is to take effect regardless of my capacity and regardless of whether or not my advance directive is in effect. This release is intended to include regarding: (initial all that apply)

_____ Alcohol and/or drug treatment

_____ Mental health treatment

_____ HIV status

The information and/or records to be released pertain to and may include any and all records and/or information regarding me that is in the possession or control of the facility or provider of services, it staff and/or agents.

This release shall remain effective so long as the attached advance directive is in effect.

Signature: _____ Date: _____

RELEASE OF MEDICAL INFORMATION:

I, _____, give permission to any health care, residential care, or nursing home facility that is providing me treatment to disclose and/or provide any information he/she/it possesses or controls, including personal observations or written records to:

This release is to take effect regardless of my capacity and regardless of whether or not my advance directives are in effect. This release is intended to include regarding: (initial all that apply)

_____ Alcohol and/or drug treatment

_____ Mental health treatment

_____ HIV status

The information and/or records to be released pertain to and may include any and all records and/or information regarding me that is in the possession or control of the facility or provider of services, its staff and/or agents.

This release shall remain effective so long as the attached advance directives are in effect.

Signature: _____ Date: _____



**YOU
COMPLETED
YOUR FORM!**

A checklist for what you should do after you signed your forms:

- Your advance directive should become an active part of your medical record. It is a good idea to discuss your choices with your case manager and treatment providers. Your Advance Directive for Health Care is more likely to be remembered and followed if you have discussed your choices.
- Give copies to your current health care providers, your health care representative and alternate. Consider giving copies to family members, close friends, the hospitals and programs where you might be taken in an emergency, your managed care firm (if you have one), your lawyer or other advocate, and other service providers. If you make changes, be sure to let everyone who has a copy know. For this reason, you'll want to keep track of who has a copy; a form for doing this is included in the kit. If you travel, be sure to take a copy of your advance directive with you and keep the original in an easily accessible place.
- Fill out the wallet card on the back cover. Carry it with you and, in an emergency, your health care providers will know that you've completed an advance directive and know to contact your health care representative.
- If you want to change your advance directive, you must complete a new form and have it signed, witnessed, and notarized. Your new advance directive will automatically replace your old one.
- Your advance directive will last forever unless you change or cancel it. We suggest that you review your document at least once a year to see if you want to make any changes.
- Your health care instructions concerning any aspect of health care, including the withholding or withdrawal of life support systems, may be revoked at any time and in any manner without regard to your mental status. However, if you want to revoke your appointment of health care representative, you must do it in writing and have it witnessed. A form has been included. If the revocation form is completed, a copy should be given to anyone who has a copy of your advance directive.

REVOCATION

My living will (my wishes concerning any aspect of my health care, including the withholding or withdrawal of life support systems) may be revoked at any time and in any manner without regard to my mental status.

However, my appointment of a Health Care Representative can only be revoked in writing, signed by me and two witnesses. The revocation of my appointment of Health Care Representative does not, of itself, revoke my Health Care Instructions.

(This page, with the revocation form on back, can be removed for later use. If the revocation form is completed, a copy should be given to anyone who has a copy of your advance directive.)

My Advance Directive for Health Care

▣ REVOCATION OF APPOINTMENT OF HEALTH CARE REPRESENTATIVE:

I, _____, revoke the appointment of _____ as my Health Care Representative in my advance directive dated _____. Any party receiving a duly executed copy or facsimile of this document may rely upon it.

Signature of Principal

Date

Initial one statement:

_____ I also revoke my Health Care Instructions.

_____ I do not revoke my Health Care Instructions. I want my Health Care Instructions to continue to serve as a legal testament of my wishes.

▣ SIGNATURE OF THE WITNESSES:

We, the subscribing witnesses, say that we witnessed the revocation of the appointment of a health care representative by the author of this document. This document was signed in our presence by the author of this document, who appeared to be eighteen years of age or older, of sound mind and able to understand the nature and consequences of health care decisions at the time this document was signed. The author appeared to be under no improper influence. We have subscribed this document in the author's presence and at the author's request and in the presence of each other on this _____ day of _____, 20 _____.

Witness (Signature)

Witness (Signature)

Witness (Print Name)

Witness (Print Name)

Street Address

Street Address

City, State and Zip Code

City, State and Zip Code

▣ HEALTH CARE REPRESENTATIVE ACCEPTANCE OF REVOCATION: (Optional but can be helpful)

I, _____, accept the revocation of appointment of Health Care Representative for _____.

Signature

Date

My Advance Directive for Health Care

Assistance is available to help you understand and complete these forms. You can have your questions answered by a trained advocate. An Instructional Guide is also available.

For addition information contact:

CT Legal Rights Project, Inc.
P.O. Box 351, Silver Street
Middletown, CT 06457
1-877-402-2299

Department of Mental Health and Addiction Services
P.O. Box 341, 410 Capitol Avenue
Hartford, CT 06134
1-800-446-7348

Office of Protection and Advocacy
60B Weston Street
Hartford, CT 06120
1-800-842-7303

Advocacy Unlimited, Inc.
Russell Road
Wethersfield, CT 06109
1-800-573-6929

We suggest filling out this card and putting it in your wallet:

In an emergency, please contact:	Release of Medical Information:	
Name: _____	I give any health facility providing treatment to me permission to notify my emergency contact people. This release is intended to include information regarding: (initial all that apply)	
I have a written Advance Directives for Health Care which is on file at:	____ Alcohol and/or drug treatment	
_____	____ Mental health treatment	
_____	____ HIV status	
Immediately contact:	Signature _____	Date _____
Health Care Representative	Emergency Advocacy Numbers:	
_____	CT Legal Rights Project, Inc.:	1-877-402-2299
_____	Dept. of Mental Health and Addiction Services:	1-800-446-7348
_____	Protection and Advocacy:	1-800-842-7303
Telephone #	Advocacy Unlimited:	1-800-573-6929

My Advance Directive for Health Care

UPDATED: OCTOBER 2006