Advance Directives

Planning for Important Healthcare Decisions

Thomaston Medical Clinic, PC

Commitment to Community since 1995

Q&A REGARDING GEORGIA DURABLE POWER OF ATTORNEY FOR HEALTH CARE

Whom should I appoint as my agent?

Your agent is the person you appoint to make your decisions about your medical care if you become unable to make those decisions yourself. Your agent can be a family member or close friend whom you trust to make serious decisions.

The person you name as your agent should clearly understand your wishes and be willing to accept responsibility of making medical decisions for you. An agent may also be called an "attorney-in-fact" or "proxy." No healthcare provider may act as your agent is he or she is directly involved in your healthcare.

You can appoint a second and third person as your alternate agent(s). The alternate will step in if the first person you name as agent is unable, unwilling, or unavailable to act for you.

How do I make Georgia Durable Power of Attorney for Health Care legal?

The law requires that you sign your document, or direct another to sign it, in the presence of two witnesses who must be at least 18 years of age.

If you are a patient in a hospital or skilled nursing facility, your document must also be signed in the presence of your doctor.

Should I add personal instructions to my Georgia Durable Power of Attorney for Health Care?

Partnership for Caring advises you not to add instructions to this document. One of the strongest reasons for naming an agent is to have someone who can respond flexibly as your medical situation changes, and deal with situations that you did not foresee. If you add instructions to this document, you might unintentionally restrict your agent's power to act in your best interest.

Instead, we urge you to talk with your agent about future medical care and describe what you consider to be an acceptable "quality of life." If you want to record your wishes about specific treatments or conditions, you should use your Georgia Living Will.

What if I change my mind?

You may revoke your Georgia Durable Power of Attorney for Health Care at any time, regardless or your mental or physical condition by:

- Obliterating, burning, tearing, or defacing your document
- Signing and dating a written revocation or directing another person to do so

OR

- Orally revoking your document in the presence of a witness, at least 18 years of age, who must sign and date a written confirmation of your revocation within 30 days.

If you get married after completing a Durable Power of Attorney for Healthcare in which you have not named your spouse as your agent, your marriage automatically revokes the power of your agent. If you have appointed your spouse as your agent and your marriage ends, your agent's power is automatically revoked.

What other important facts should I know?

Section 6 of your Durable Power of Attorney for Healthcare provides space where you can nominate someone to serve as your guardian if there should come a time when you need a court-appointed guardian. Unless a court specifies otherwise, your guardian has no power to make any personal or health care decisions granted to your agent under your Durable Power of Attorney for Health Care.

GEORGIA STATUTORY SHORT FORM DURABLE POWER OF ATTORNEY FOR HEALTH CARE

Notice: The purpose of this power of attorney is to give the person you designate (your agent) broad powers to make health care decisions for you, including power to require, consent to, or withdraw any type of personal care or medical treatment for any physical or mental condition and to admit institution; but not including psychosurgery, sterilization, or involuntary hospitalization or treatment covered by Title 37 of the Official Code of Georgia Annotated. This form does not impose a duty on your agent to exercise granted powers; but, when a power is exercised, your agent will have to use due care to act for your benefit and in accordance with this form. A court can take away the powers of your agent if it finds the agent is not acting properly. You may name co-agents and successor agents under this form, but you may not name a health care provider who may be directly or indirectly involved in rendering healthcare to you under this power. Unless you expressly limit the duration of this power in the manner provided below, or until you revoke this power or a court acting on your behalf terminates it, your agent may exercise the powers given in this power throughout your lifetime, even after you become disabled, incapacitated, or incompetent. The powers you give your agent, your right to revoke those powers, and the penalties for violating the law are explained more fully in Code Sections 31-36-6, 31-36-9, and 31-36-10 of the Georgia “Durable Power of Attorney for Health Care Act” of which this form is a part. That act expressly permits the use of any different form of power of attorney you may desire. If there is anything about this form that you do not understand, you should ask a lawyer to explain it to you.

GEORGIA STATUTORY SHORT FORM DURABLE POWER OF ATTORNEY FOR HEALTH CARE

Instructions	Document
Fill in the date	DURABLE POWER OF ATTORNEY made this ____ day of _____, 20_____.
Fill in your name	I, _____ *(name)*
Fill in your address	at _____ , *(address)*
Fill in your agent's name	hereby appoint: _____ , *(name of agent)*
Fill in your agent's address	at _____ , *(address of agent)*

as my attorney in fact (my agent) to act for me and in my name in any way I could act in person to make any and all decisions for me concerning my personal care, medical treatment, hospitalization, and treatment or procedure, even though my death may ensue. My agent shall have the same access to my medical records that I have, including the right to disclose the content to others. My agent shall also have full power make a disposition of any part to all of my body for medical purposes, authorize an autopsy of my body, and direct the deposition of my remains.

THE ABOVE GRANT OF POWER IS INTENDED TO BE AS BROAD AS POSSIBLE SO THAT YOUR AGENT WILL HAVE AUTHORITY TO MAKE ANY DECISION YOU COULD MAKE TO OBTAIN OR TERMINATE ANY TYPE OF HEALTHCARE, INCLUDING WITHDRAWAL OF NOURISHMENT AND FLUIDS AND OTHER LIFE-SUSTAINING OR DEATH-DELAYING MEASURES, IF YOUR AGENT BELIEVES SUCH ACTION WOULD BE CONSISTENT WITH YOUR INTENT AND DESIRES. IF YOU WISH TO LIMIT THE SCOPE OF YOUR AGENT'S POWERS OR PRESCRIBE SPECIAL RULES TO LIMIT THE POWER TO MAKE AN ANATOMICAL GIFT, AUTHORIZE AUTOPSY, OR DISPOSE REMAINS, YOU MAY DO SO IN THE FOLLOWING PARAGRAPHS:

The powers granted above shall not include the following powers or shall be subject to the following rules or limitations:

Document limitations and other provisions to your agent's power (if necessary)

_____

_____

_____

_____

_____

(Here you may include any specific limitations you deem appropriate, such as your own definition of when life-sustaining or death-delaying measures should be withheld; a direction to continue nourishment and fluids or other life-sustaining or dearth-delaying treatment in all events; or instructions to refuse any specific types of treatment that are inconsistent with your religious beliefs or unacceptable to you for any other reason, such as blood transfusion, electroconvulsive therapy, or amputation.)

THE SUBJECT OF LIFE-SUSTAINING OR DEATH-DELAYING TREATMENT IS OF PARTICULAR IMPORTANCE. FOR YOUR CONVENIENCE IN DEALING WITH THAT SUBJECT, SOME GENERAL STATEMENTS CONCERNING THE WITHHOLDING OR REMOVAL OF LIFE-SUSTAINING OR DEATH-DELAYING TREATMENT ARE SET FORTH BELOW. **IF YOU AGREE WITH ONE OF THESE STATEMENTS, YOU MAY INITIAL THAT STATEMENT, BUT DO NOT INITIAL MORE THAN ONE.**

(_____) I do not want my life to be prolonged nor do I want life-sustaining or death-delaying treatment to be provided or continues if my agent believes that the burdens of the treatment outweigh the expected benefits. I want my agent to consider the relief of suffering, the expense involved, and the quality as well as the possible extension of my life in making decisions concerning life-sustaining or death-delaying treatment.

Choose the statement that best reflects your wish.

(_____) I want my life to be prolonged and I want life-sustaining or death-delaying treatment to be provided or continued unless I am in a coma, including a persistent vegetative state, which my attending physician believes to be irreversible, in accordance with reasonable medical standards at the time of reference. If and when I have suffered such an irreversible coma, I want life-sustaining or death-delaying treatment to be withheld or discontinued.

(_____) I want my life to be prolonged to the greatest extent possible without regard to my condition, the chances I have for recovery, or the cost of the procedures.

THIS POWER OF ATTORNEY MAY BE AMENDED OR REVOKED BY YOU AT ANY TIME AND IN ANY MANNER WHILE YOU ARE ABLE TO DO SO. IN THE ABSENCE OF AN AMENDMENT OR REVOCATION, THE AUTHORITY GRANTED IN THE POWER OF ATTORNEY WILL BECOME EFFECTIVE AT THE TIME THIS POWER IS SIGNED AND WILL CONTINUE UNTIL YOUR DEATH AND WILL CONTINUE BEYOND YOUR DEATH IF ANATOMICAL GIFT, AUTOPSY, OR DISPOSITION OF REMAINS IS AUTHORIZED, UNLESS A LIMITATION ON THE BEGINNING DATE OR DURATION IS MADE BY INITIALING AND COMPLETING EITHER OR BOTH OF THE FOLLOWING:

(_____) This power of attorney shall become effective on _____

Begin Date *(optional)*

_____

(select a date or event during your lifetime, such as court determination of your disability, incapacity, or incompetency, when you want this power to first take effect)

(_____) This power of attorney shall terminate on _____

End Date *(optional)*

_____

(select a date or event during your lifetime, such as court determination of your disability, incapacity, or incompetency, when you want this power to terminate prior to your death)

IF YOU WISH TO NAME SUCCESSOR AGENTS, INSERT THE NAMES AND ADDRESSES OF SUCH SUCCESSORS IN THE FOLLOWING PARAGRAPH:

If any agent named by me shall die, become legally disabled, incapacitated, or incompetent, or resign, refuse to act, to be unavailable, I name the following (each to act successively in the order named) as successors to such agent:

First Alternate

Name: _____

Address: _____

Second Alternate

Name: _____

Address: _____

IF YOU WISH TO NAME A GUARDIAN OF YOUR PERSON IN THE EVENT A COURT DECIDES THAT ONE SHOULD BE APPOINTED, YOU MAY, BUT ARE NOT REQUIRED TO, DO SO BY INSERTING THE NAME OF SUCH GUARDIAN IN THE FOLLOWING PARAGRAPH. THE COURT WILL APPOINT THE PERSON NOMINATED BY YOU IF THE COURT FINDS THAT SUCH APPOINTMENT WILL SERVE YOUR BEST INTERESTS AND WELFARE. YOU MAY, BUT ARE NOT REQUIRED TO, NOMINATE THE SAME PERSON NAMED IN THIS FORM AS YOUR AGENT.

If a guardian of my person is to be appointed, I nominate the following to serve as such guardian:

Print the name and address of a guardian. (optional)

_____

(name of guardian)

_____

(address of guardian)

I am fully informed as to all the contents of this form and understand the full import of this grant of powers to my agent.

Sign the Document

Signed: _____

(principal)

Witnessing Procedures

The principal has had an opportunity to read the above form and has signed the above form in our presence. We, the undersigned, each being over 18 years of age, witness the principal's signature at the request and in the presence of the principal, and in the presence of each other, on the day and the year above set out.

Witness: _____

Your two witnesses must sign and print their addresses.

Address: _____

Witness: _____

Address: _____

Additional witness required when health care agency is signed in a hospital or skilled nursing facility.

Residents of a hospital or nursing home need one additional witness.

I hereby witness this health care agency and attest that I believe that principal to be of sound mind and to have made this health care agency willingly and voluntarily.

Witness (Attending Physician): _____

Address: _____

YOU MAY, BUT ARE NOT REQUIRED TO, REQUEST YOUR AGENT AND SUCCESSOR AGENTS TO PROVIDE SPECIMEN SIGNATURES BELOW. IF YOU INCLUDE SPECIMEN SIGNATURES IN THIS POWER OF ATTORNEY, THEN YOU MUST COMPLETE THE CERTIFICATION OPPOSITE THE SIGNATURES OF THE AGENTS.

Sample signatures of your agent and alternates (optional)

_____ (agent) _____ (principal)

_____ (successor agent) _____ (principal)

_____ (successor agent) _____ (principal)

Instructions	Document
Print the Date	Living will made this _____ day of _____ (month, year).
Print your Name	I, _____ *(name)*

being of sound mind, willfully and voluntarily make known my desire that my life shall not be prolonged under the circumstances set forth below, and do declare:

1. If at any time I should *(check each option desired)*:

Check the options that apply

_____ have a terminal condition.

_____ become in a coma with no reasonable expectation of regaining consciousness, or

_____ become in a persistent vegetative state with no reasonable expectation of regaining significant cognitive function,

as defined in and established in accordance with the procedures set forth in paragraphs (2), (9), (13) of Code Section 31-32-2 of the Official Code of Georgia Annotated, I direct that the application of life-sustaining procedures to my body be withheld or withdrawn and that I be permitted to die.

With regard to artificially supplied nutrition and hydration, I direct that *(check the option desired)*:

Check the options that reflect your wishes about artificial feeding.

_____ artificial nutrition be provided.

_____ artificial nutrition be withheld or withdrawn.

_____ artificial hydration be provided.

_____ artificial hydration be withheld or withdrawn.

Other directions: (optional)

Add personal instructions (if any).

_____

_____

_____

_____

_____

_____

_____

_____

2. In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intentions that this living will shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatments and accept the consequences from such refusal;

3. I understand that I may revoke this living will at any time;

4. I understand the full import of this living will, and I am at least 18 years of age and am emotionally and mentally competent to make this living will; and

Initial here if this statement reflects your wishes.

5. If I have been diagnosed as pregnant, I want this living will to be carried out despite my pregnancy.

_____ *(initial)*

Signed: _____

Sign the document and print your city, county, and state of residence.

City: _____

County: _____

State of Residence: _____

I hereby witness this living will and attest that:

1. The declarant is personally known to me and I believe the declarant to be at least 18 years of age and of sound mind;
2. I am at least 18 years of age;
3. To the best of my knowledge, and the time of the execution of this living will, I:

Witnessing Procedures

   A. Am not related to the declarant by blood or marriage;
   B. Would not be entitled to any portion of the declarant's estate by any will or by operation of law under the rules of descent and distribution of this state;
   C. Am not the attending physician of declarant or an employee of the attending physician or an employee of the hospital or skilled nursing facility in which declarant is a patient;
   D. Am not directly financially responsible for the declarant's medical care; and
   E. Have no present claim against any portion of the estate of the declarant;

4. Declarant has signed the document in my presence as above instructed, on the date above first shown.

Witness #1

Witness: _____

Address: _____

Witness #2

Witness: _____

Address: _____

Additional witness requires when living will is signed by a patient in a hospital or skilled nursing facility.

Residents of a hospital or nursing home must have one additional witness.

I hereby witness this living will and attest that I believe the declarant to be of sound mind and to have made this living will willingly and voluntarily.

Witness: _____

(Medical director of skilled nursing facility or staff physician not participating in care of the patient, or chief of the hospital medical staff or staff physician or hospital designee not participating in care of the patient.)

How do I make my Living Will legal?

The law requires that you sign your Living Will in the presence of two witnesses, who must also sign the document to show that they personally know you and believe you to be of sound mind, that you signed the document in their presence, that they are 18 years of age or older, and that they do not fall into any of the categories of people who cannot be witnesses.

The following people cannot be witnesses of your Living Will:

Anyone related to you by blood or marriage.

Anyone who is financially responsible for your medical care.

Anyone who is entitled to any part of your estate upon your death.

Anyone who has a claim against any portion of your estate.

Anyone who is your doctor, or a person employed by your doctor

Anyone who is an employee of a healthcare facility in which you are a patient.

If you are a patient in a hospital or skilled nursing facility, you are required to have a third witness.

If you are in a hospital, this third witness must be either the chief of the medical staff, a staff physician, or another person designated by the hospital administrator.

If you are in a skilled nursing facility, this third witness must be either the medical director or a physician on the medical staff.

Your third witness **cannot** be involved in your medical care.

Note: You do not need to notarize your Georgia Living Will

Can I add personal instructions to my Living Will?

Yes. You can add personal instructions in the part of the document called “Other Directions.” For example, you may want to refuse specific treatments by a statement such as, “I especially do not want cardiopulmonary resuscitation, a respirator, or antibiotics.”

You may also want to emphasize pain control by adding instructions such as, “I want to receive as much pain medication as necessary to ensure my comfort, even if it may hasten my death.”

If you want to refuse artificial nutrition, artificial hydration, or both, you must check the appropriate options in Section 1.

If you have appointed an agent and you want to add personal instructions to your Living Will, it is a good idea to write a statement such as, “Any questions about how to interpret to when to apply my Living Will are to be decided by my agent.”

What if I change my mind?

You can revoke your Georgia Living Will at any time, regardless of your mental condition by:

Destroying the document.

Signing and dating a written revocation, or directing another person to do so in your presence, or

Orally or otherwise expressing your intent to revoke your Living Will.

Your doctor must be notified of your revocation for it to be effective.

What other important facts should I know?

If you are a person of child-bearing age and would like your Georgia Living Will to be honored even if you are pregnant, you must initial the statement in paragraph 5 of the Living Will form.

State law requires that before honoring a pregnant patient's Living Will, the attending physician must first determine whether the fetus is viable. If the fetus is viable, your Living Will will not be honored, *even if you initial paragraph 5.*

AFTER YOU HAVE COMPLETED YOUR DOCUMENTS

1. Your Georgia Durable Power of Attorney for Health Care and Georgia Living Will are important legal documents. Keep the original signed documents in a secure but accessible place. Do not put the original documents in a safe deposit box or any other security box that would keep others from having access to them.
2. Give photocopies of the signed originals to your agent and alternate agent, doctor(s), family, close friends, clergy, and anyone else who might become involved in your health care. If you enter a nursing home or hospital, have photocopies of your documents placed in your medical records.
3. Be sure to talk to your agent and alternates, doctor(s), clergy, and family and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.
4. If you want to make changes to your documents after they have been signed and witnessed, you must complete new documents.
5. Remember, you can always revoke one or both of your Georgia documents.
6. Be aware that your Georgia documents will not be effective in the case of a medical emergency. Ambulance personnel are required to provide CPR unless they are given a separate order that states otherwise. These orders, commonly called "nonhospital do-not-resuscitate orders," are designed for people whose poor health gives them little chance of benefitting from CPR. These orders must be signed by your physician and instruct ambulance personnel not to attempt CPR if your heart or breathing should stop. Currently, not all states have laws authorizing non hospital do-not-resuscitate orders.