

**LIVING WILL DIRECTIVE AND
HEALTH CARE SURROGATE DESIGNATION
PURSUANT TO KRS § 311.625**

My wishes regarding life-prolonging treatment and artificially provided nutrition and hydration to be provided to me if I no longer have decisional capacity, have a terminal condition, or become permanently unconscious have been indicated by checking and initialing the appropriate lines below. By checking and initialing the appropriate lines, I specifically:

Designate _____ (name of surrogate) as my health care surrogate to make health care decisions for me in accordance with this directive when I no longer have decisional capacity.

If my surrogate so named by me shall die, become legally disabled, incapacitated, or incompetent, or should resign, refuse to act, or be unavailable to act, I designate

_____ (name of alternate surrogate) as my alternate health care surrogate.

Any prior designation is revoked.

If I do not designate a surrogate, the following are my directions to my attending physician. If I have designated a surrogate, my surrogate shall comply with my wishes as indicated below.

Section A: Life-Prolonging Treatment (Check and Initial Only One)

_____ I direct that treatment be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical treatment deemed necessary to alleviate pain.

_____ I DO NOT authorize that life-prolonging treatment be withheld or withdrawn.

Section B: Artificial Nutrition and Hydration (Check and Initial Only One)

_____ I authorize my surrogate, designated above, to withhold or withdraw artificially provided nourishment or fluids, or other treatment if the surrogate determines that withholding or withdrawing is in my best interest; but I do not mandate that withholding or withdrawing. Withholding or withdrawing artificially provided nourishment or fluids, or other treatment shall only be considered to be "in my best interest" if (a) death is imminent; (b) I am unable to assimilate artificially provided nourishment or fluids; or (c) the artificial nutrition or hydration is unduly burdensome for me.

_____ I DO NOT authorize the withholding or withdrawal of artificially provided food, water, or other artificially provided nourishment or fluids.

Section C: Organ Donation (Check and Initial Only One)

_____ I authorize the giving of my organs upon death for any purpose specified in K.R.S. § 311.1929, except that my reproductive organs, tissues, and cells may not be given to any person for the purpose of creating human embryos.

_____ I DO NOT authorize the giving of all or any part of my body upon death.

Section D: Special Instructions for My Health Care Surrogate

I wish to follow the moral teachings of the Catholic Church and to receive all the obligatory care that my faith teaches we have a duty to accept. However, I also know that death need not be resisted by any and every means, and that I have the right to refuse medical treatment that is excessively burdensome or would only add to my suffering as I face inevitable death. I also know that I may morally receive medication necessary to relieve my pain even if it is foreseen that its use may have the unintended result of shortening my life.

I direct my health care surrogate to make healthcare decisions on my behalf in accord with the moral teachings of the Catholic Church. In making decisions on my behalf, my health care surrogate should be guided by the moral teachings of the Catholic Church contained in, but not limited to, the following documents:

- 1) *Declaration on Euthanasia*, Congregation for the Doctrine of the Faith, 1980;
- 2) *Evangelium Vitae*, Pope John Paul II, 1995.
- 3) *Address to the Eighteenth International Congress of the Transplantation Society*, Pope John Paul II, August 29, 2000;

- 4) *Ethical and Religious Directives for Catholic Health Care Services*, United States Conference of Catholic Bishops, 2009;
- 5) *On Life-Sustaining Treatments and the Vegetative State*, Pope John Paul II, March 20, 2004.

If I fall terminally ill, I ask that I be told of this so that I might prepare myself for death, and I ask that efforts be made that I be attended by a Catholic priest and receive the Sacraments of Reconciliation and Anointing of the Sick, as well as Viaticum.

Other instructions for my health care surrogate:

Section E: HIPAA Personal Representative

My surrogate shall be my personal representatives for all purposes under the HIPAA Privacy Rule. As a personal representative for me under the HIPAA Privacy Rule, my surrogate shall be permitted to exercise all of my rights under HIPAA with respect to my protected health information (as defined in 45 CFR Statutory Section 160.103) without any further authorization or consent by me. Such rights include, but are not limited to: (a) the right of access to my protected health information; (b) the right to request an amendment to my protected health information; (c) the right to request an accounting of disclosures or my protected health information; (d) the right to request restrictions on the use or disclosures of my protected health information; (e) the right to request alternate means or locations for the communication of my protected health information; and (f) the right to authorize disclosures of my protected health information. All references to the HIPAA Privacy Rule are to the regulations governing the standards for a Privacy of Individually Identifiable Health Information at 45 CFR Parts 160 and 164 that were issued pursuant to the Health Insurance Portability and Accountability Act of 1996.

Section F: Other Provisions

By completing this document, I intend to create an Advance Directive under Chapter 311 of the Revised Statutes of the Commonwealth of Kentucky. In the absence of my ability to give directions regarding the use of life-prolonging treatment and artificially provided nutrition and hydration, it is my intention that this directive shall be honored by my attending physician, my family, and any surrogate designated pursuant to this directive as the final expression of my legal right to refuse medical or surgical treatment and I accept the consequences of the refusal.

I revoke any prior Advance Directive document.

This Advance Directive document is intended to be valid in any jurisdiction in which it is presented.

A photocopy of this Advance Directive document may be relied upon as though it were the original.

I understand the full import of this directive and I am emotionally and mentally competent to make this directive.

Signed this _____ day of _____, 20_____.

SIGNATURE OF GRANTOR: _____

PRINT NAME OF GRANTOR: _____

GRANTOR'S ADDRESS: _____

Pursuant to KRS § 311.625(2), this form is required to be witnessed by two or more adults in the presence of the grantor and in the presence of each other, OR acknowledged before a notary public or other person authorized to administer oaths. None of the following shall be a witness to or serve as a notary public or other person authorized to administer oaths in regard to any advance directive made under this section:

- (a) A blood relative of the grantor;*
- (b) A beneficiary of the grantor under descent and distribution statutes of the Commonwealth;*
- (c) An employee of a health care facility in which the grantor is a patient, unless the employee serves as a notary public;*
- (d) An attending physician of the grantor; or*
- (e) Any person directly financially responsible for the grantor's health care.*

