ORIGINAL

Prepared by:	**LEGAL AID SOCIETY OF HAWAI'I** **3016 Umi Street, Suite 208** **Lihue, Hawaii 96766**
Grantor: **Address and Phone:**	**LILA T. ALSTON** **P.O. BOX 3170** **LIHUE, HI 96766** **808-378-4467**
Agent: **Address and Phone:**	**BRIAN C. ALSTON** **P.O. BOX 3170** **LIHUE, HI 96766** **808-217-1831**
Alternate Agent: **Address and Phone:**	**THERESA ALSTON** **4759 BRIARBEND TRCE** **STONE MOUNTAIN, GA 30088** **678-910-3937**
Alternate Agent: **Address and Phone:**	**HAROLD ALSTON** **225 POPLAR ST.** **WINNSBORO, SC 29180** **803-635-9367**

ADVANCE HEALTH CARE DIRECTIVE

You have the right to give instructions about your own health care. You also have the right to name someone else to make health care decisions for you. This document lets you do either or both of these things. It also lets you express your wishes regarding the designation of your primary physician.

PART 1 of this document is a power of attorney for health care and lets you name another individual as agent to make health care decisions for you if you become incapable of making your own decisions or if you want someone else to make those decisions for you now even though you are still capable. You may name an alternate agent to act for you if your fist choice is not willing, able, or reasonably available to make decisions for you. Unless related to you, your agent may not be an owner, operator, employee of a residential long-term health care institution at which you are receiving care.

Unless you limit the authority of your agent herein, your agent **may make all health care decisions for you**. This document has a place for you to limit the authority of your agent. You need not limit the authority of your agent if you wish to rely on your agent for all health care decision that may have to be made.

Part 2 of this document lets you give specific instructions about any aspect of your health care. Choices are provided to you to express your wishes regarding the provision, withholding, or withdrawal for treatment to keep you alive, including the provision of artificial nutrition and hydration, as well as the provision of pain relief.

Part 3 of this document lets you donate organs at death if you want to.

Part 4 of this document lets you designate a physician to have primary responsibility for your health care and contains miscellaneous provisions and space to add any other wishes you may have.

PART 1

I, **LILA T. ALSTON** of, P.O. BOX 3170, Lihue, Hawaii, 96766, hereby designate and appoint BRIAN C. ALSTON as my attorney-in-fact (hereinafter referred to as "Agent") to make health care decisions authorized in this document. If BRIAN C. ALSTON is not available or becomes ineligible to act as my Agent to make a health care decision for me or loses mental capacity to make health care decisions for me, or if I revoked that person's appointment or authority to act as my Agent to make health care decisions for me, then I designate and appoint THERESA ALSTON to serve as my agent to make health care decisions for me as authorized in this document. If THERESA ALSTON is not available or becomes ineligible to act as my Agent to make a health care decision for me or loses mental capacity to make health care decisions for me, or if I revoked that person's appointment or authority to act as my Agent to make health care decisions for me, then I designate and appoint HAROLD ALSTON to serve as my agent to make health care decisions for me as authorized in this document.

For the purposes of this document, "health care decision" means consent, refusal of consent, or withdrawal of consent in any care, treatment, service or procedure to maintain, diagnose, or treat my physical or mental condition.

1. General Statement of Authority Granted. Subject to any limitations in this document, I hereby grant to my Agent full authority to make health care decisions for me to the same extent that I could make such decisions for myself if I had the capacity to do so, including decisions to provide, withhold, or withdraw artificial nutrition and hydration, and all other forms of health care to keep me alive except as stated here:

None.

2. Agent's Obligation. In making decisions, my Agent shall attempt to discuss the proposed decision with me to determine my desires if I am able to communicate in any way. If my Agent cannot determine the choice I would want made, my Agent shall make health care decisions that are consistent with my desires as stated in this document or otherwise made known to my Agent, including, but not limited to my desires concerning obtaining or refusing or withdrawing life-prolonging care, treatment, services and procedures. "Life-prolonging" means any medical procedure or intervention, including the artificial provisions of fluids, nourishment, medication or other procedures that when administered to a patient, will serve only to prolong the dying process, but does not include procedures necessary for patient comfort or relief of pain.

3. When Agent's Authority Becomes Effective. My Agent's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions unless I mark the following box:

L.T.A. ☒ If I mark and initial next to this box my Agent's authority to make health care decisions for me takes effect immediately. **However, I always retain the right to make my own decisions about my health care and to revoke this authority as long as I am mentally capacitated.**

☐ If I mark and initial next to this box my Agent's authority under section 9.4 of this Advance Health Care Directive takes place immediately to the extent necessary for my primary physician to receive and distribute information necessary to determine whether or not I am able to make my own health care decisions.

PART 2

4. End of Life Decisions. I direct that my health care provider and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked down.

☐ (a) Choice **Not To Prolong Life**: If I mark and initial next to the box, I DO NOT want my life to be prolonged if:

i. I have an incurable and irreversible disease, illness injury or condition of which is such that the administration of one or more life-sustaining procedures will, as a medical probability, only serve to delay the moment of death for a relatively short period of time measured in weeks; or

ii. I become permanently unconscious which means a state as diagnosed by a physician as being in a persistent vegetative state or in a deep coma with no reasonable expectation of regaining consciousness; or

iii. I have permanent loss of the capacity to participate in medical treatment decisions, secondary to severe neurological or brain damage, with no reasonable expectation of regaining this capacity; or

iv. I will not regain consciousness to a reasonable degree of medical certainty; or

v. The likely risks and burdens of treatment would outweigh the expected benefits.

LPA ☒ (b) Choice **To Prolong Life**: If I mark and initial next to the box, I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

5. Artificial Nutrition and Hydration. I direct that artificial nutrition and/or hydration must be provided, withheld, or withdrawn in accordance with the choice I have made in paragraph 4 unless I mark the following box:

___ ☐ If I mark and initial next to this box, I direct that artificial nutrition **must be provided** regardless of my condition and regardless of the choice I have made in paragraph 4.

___ ☐ If I mark and initial next to this box, I direct that hydration **must be provided** regardless of the choice I have made in paragraph 4.

6. Relief From Pain. I direct that treatment for alleviation of pain or discomfort be provided at all times, even if such pain relief treatment hastens my death.

___ ☐ If I mark and initial next to this box, I direct that treatment for alleviation of pain or discomfort **must NOT be provided** regardless of my condition and regardless of the choice I have made in paragraph 4.

7. Power to Maintain Me in My Residence. My Agent is authorized to take whatever steps are necessary or advisable to enable me to remain in my personal residence as along as it is reasonable under the circumstances. I realize that my health may deteriorate so that it becomes necessary to have round-the-clock nursing care if I am to remain in my personal residence, and I direct my Agent to obtain such care (including any equipment that might assist in such care) as is reasonable under the circumstances.

___ ☐ If I mark and initial next to this box, I DO NOT want to be hospitalized or put in a convalescent or similar home **as long as it is reasonable** to maintain me in my personal residence.

8. Statement of Desires, Special Provisions, and Limitations. My agent is authorized to give, withhold, withdraw or modify consent to any and all medical, dental, nursing, and hospital care and treatment, either preventive or corrective, including major surgery and long term care deemed necessary by a duly licensed physician or dentist for my health and well being at a hospital or other licensed health care or residential facility, to include short and long term treatment facilities, convalescent centers and care homes.

9. Inspection and Disclosure of Information Relating to my Physical or Mental Health. Subject to any limitation in this document, my Agent has the power and authority to do al the following:

9.1 Request, review, and receive any information, verbal or written, regarding my physical or mental health, including, but not limited to, medical and hospital records.

9.2 Execute on my behalf any releases or other documents that may be required in order to obtain this information.

9.3 Consent to disclosure of this information.

9.4 HIPAA RELEASE INFORMATION. I intend for my Agent to be treated as I would be in 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 Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 42 U.S.C. 1320d and 45 C.F.R. 160-164. I authorize:

Any physician, health care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy or other covered health care provider, any insurance company and the Medical Information Bureau, Inc., or other health care clearinghouse that has provided treatment or services to me, or that has paid for or is seeking payment from me for such services;

To give, disclose and release to my Agent, without restriction, all of my individually identifiable health information and medical records regarding any past, present or future medical or mental health condition, include (if applicable) all information relating to the diagnosis and treatment of HIV/AIDS, sexually transmitted diseases, mental illness and drug or alcohol abuse.

The authority given my Agent shall supersede any prior agreement that I may have made with my health care providers to restrict access to or disclosure of my individually identifiable health

information. The authority given my Agent has no expiration date and shall expire only in the event that I revoke the authority in writing and deliver it to my health care provider.

10. Signing Documents, Waivers and Releases. Where necessary to implement the health care decisions that my Agent is authorized by this document to make, my Agent has the power and authority to execute on my behalf all of the following:

10.1 Any necessary form to approve or disapprove diagnostic tests, surgical procedures, programs or medication, and orders not to resuscitate.

10.2 Documents titled or purporting to be a "Refusal to Permit Treatment" and "Leaving Hospital Against Medical Advice."

10.3 Any necessary waiver or release from liability required by a hospital or physician

11. Authority to Visit. My Agent shall have the authority to visit me in any medical, nursing, residential or similar facility and may authorize other individuals who may not be related to me to visit me.

12. Admission to or Discharge from HealthCare Facilities. My Agent shall have the power to authorize my admission to or discharge from any medical, nursing, residential or similar facility and to arrange, contract for, and pay for consultation, diagnosis or services as may be required for my care, without my Agent incurring any personal financial liability. My Agent is authorized to employ, compensate and discharge such medical and professional personnel including, doctors, nurses, physical therapists, medical advisors, medical consultants, companions, servants and employees as my Agent deems appropriate.

13. Nomination of Guardian. If a guardian of my person for any reason be appointed, I nominate my Agent, name above. If that Agent is not willing, able, or reasonably available to act as guardian, I nominate the alternate agents who I have named, in the order designated.

PART 3

14. Organ Donation. (A) Upon my death:

LTA ☒ I do not want to make any donation

☐ I give any needed organs, tissues or parts.

☐ I give the following organs, tissues, or parts only: _____

(B) My gift is for the following purposes (strike any of the following you **DO NOT** want):

(I) Transplant
(II) Therapy
(III) Research
(IV) Education

PART 4

15. Designation of Primary Physician. I designate the following physician as my primary physician:

If the physician I have designated above is not willing, able or reasonably available to act as my primary physician, I designate the following physician as my primary physician:

Attending Physician

16. Reliance on Photocopies. Any person dealing with the Agent designated hereunder shall have the right to rely on a photocopy of this Advance Health Care Directive as if it were the signed, original Advance Health Care Directive.

17. Prior Advance Health Care Directive Revoked. I revoke any prior Advance Health Care Directive, Living Will, or Health Care Power of Attorney.

18. Witnesses. This document will not be valid for making health care decisions unless it is either (a) signed by two qualified adult witnesses who are personally known to you and who are present when you sign or acknowledge your signature; or (b) acknowledged before a notary public in the state.

19. Other Wishes. (If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:

ALLERGIC TO HYDROCHLOROTHIAZIDE AND DIAVON.

I understand the full meaning of this Advance Health Care Directive and I am emotionally and mentally competent to make this declaration.

9.29.2014 Lila T. Alston

Date LILA T. ALSTON

STATE OF HAWAI`I)
) SS.
COUNTY OF KAUAI)

On this 29TH day of September, 2014, before me appeared LILA T. ALSTON , personally known to me or satisfactorily proved to me to be the person whose name is subscribed to this instrument, and acknowledged that he/she executed as his/her free act and deed

Irma B. Garcia

IRMA B. GARCIA NOTARY PUBLIC 13-363 STATE OF HAWAII

Notary Public, Fifth Judicial Circuit
State of Hawai`i
My commission expires: 10/06/2017
Commission number: 13-363

Doc Date: 9/29/14 # Pages: 8
Name: Irma B. Garcia Fifth Judicial Circuit
Doc Description: **Advance Health Care Directive**

Signature 9/29/14
Date

NOTARY CERTIFICATION
(SEAL)

IRMA B. GARCIA NOTARY PUBLIC 13-363 STATE OF HAWAII