Health Care Power of Attorney
For North Carolina

A Practical Form for All Adults

Introduction

This form allows you to express your wishes for future health care and to guide decisions about that care. It does not address financial decisions. Although there is no legal requirement for you to have a health care power of attorney, completing this form may help you to receive the health care you desire.

If you are 18 years old or older and are able to make and communicate health care decisions, you may use this form.

This form complies with North Carolina law (in NCGS § 32A-15 through 32A-27).

1. **What is a health care power of attorney?** A health care power of attorney is a legal document in which you name another person, called a "health care agent," to make health care decisions for you when you are not able to make those decisions for yourself.
2. **Who can be a health care agent?** Any competent person who is at least 18 years old and who is not your paid health care provider may be your health care agent.
3. **How should you choose your health care agent?** You should choose your health care agent very carefully, because that person will have broad authority to make decisions about your health care. A good health care agent is someone who knows you well, is available to represent you when needed, and is willing to honor your wishes. It is very important to talk with your health care agent about your goals and wishes for your future health care, so that he or she will know what care you want.
4. **What decisions can your health care agent make?** Unless you limit the power of your health care agent in Section 2 of this form, your health care agent can make <u>all</u> health care decisions for you, including:
    - starting or stopping life-prolonging measures
    - decisions about mental health treatment
    - choosing your doctors and facilities
    - reviewing and sharing your medical information
    - autopsies and disposition of your body after death
5. **Can your health care agent donate your organs and tissues after your death?** Yes, if you choose to give your health care agent this power on the form. To do this, you must initial the statement in Section 3.
6. **When will this health care power of attorney be effective?** This document will become effective if your doctor determines that you have lost the ability to make your own health care decisions.

7. **How can you revoke this health care power of attorney?** If you are competent, you may revoke this health care power of attorney in any way that makes clear your desire to revoke it. For example, you may destroy this document, write "void" across this document, tell your doctor that you are revoking the document, or complete a new health care power of attorney.
8. **Who makes health care decisions for me if I don't name a health care agent and I am not able to make my own decisions?** If you do not have a health care agent, NC law requires health care providers to look to the following individuals, in the order listed below: legal guardian; an attorney-in-fact under a general power of attorney (POA) if that POA includes the right to make health care decisions; a husband or wife; a majority of your parents and adult children; a majority of your adult brothers and sisters; or an individual who has an established relationship with you, who is acting in good faith and who can convey your wishes. If there is no one, the law allows your doctor to make decisions for you as long as another doctor agrees with those decisions.

Completing this Document

To make this advance directive legally effective:

1. Wait until two witnesses and a notary public are present, then sign and date the document.
2. Two witnesses must sign and date the document. These witnesses cannot be:
   - related to you by blood or marriage,
   - your heir, or a person named to receive a portion of your estate in your will,
   - someone who has a claim against you or against your estate, or
   - your doctor, other health care provider, or an employee of a hospital in which you are a patient, or an employee of the nursing home or adult care home where you live.
3. A notary public must witness these signatures and notarize the document.

My name is: _____ **My birth date is**: __/__/_____
(Please Print)

1. The person I choose as my health care agent is:

first name	middle name	last name	
street address	city	state	zip code
home phone	work phone	cell phone	e-mail address

If this person is unable or unwilling to serve as my health care agent, my next choice is:

first name	middle name	last name	
street address	city	state	zip code
home phone	work phone	cell phone	e-mail address

2. Special Instructions:

NOTE: In this section, you may include **any special instructions** you want your health care agent to follow, or **any limitations** you want to put on the decisions your health care agent can make, including decisions about tube feeding, other life-prolonging treatments, mental health treatments, autopsy, disposition of your body after death, and organ donation. If you need additional space, please use the back of this page.

If you do not have any special instructions for your health care agent, or any limitations you want to put on your agent's authority, please draw a line through this section.

_____

_____

_____

3. Organ Donation:

_____ (initial) My health care agent may donate my organs, tissues, or parts after my death.

(Please note: if you do not initial above, your health care agent will not be able to donate your organs or parts.)

Completing this Document (wait until two witnesses and a notary public are present before you sign!)

4. **Your Signature**

I am mentally alert and competent, and I am fully informed about the contents of this document.

Date:_____ Signature: _____

5. Signatures of Witnesses

I hereby state that the person named above, being of sound mind, signed (or directed another to sign on the person's behalf) the foregoing document in my presence. I am not related to the person by blood or marriage, and I would not be entitled to any portion of the estate of the person under any existing will or codicil of the person or as an heir under the law, if the person died on this date without a will. I am not the person's attending physician. I am not a licensed health care provider or mental health treatment provider who is (1) an employee of the person's attending physician or mental health treatment provider, (2) an employee of the health facility in which the person is a patient, or (3) an employee of a nursing home or any adult care home where the person resides. I do not have any claim against the person or the estate of the person.

Date: _____ Signature of Witness: _____

Date: _____ Signature of Witness: _____

6. Notarization

_____ COUNTY, _____ STATE

Sworn to (or affirmed) and subscribed before me this day by

_____ *(type/print name of signer)*

_____ *(type/print name of witness)*

_____ *(type/print name of witness)*

Date: _____ _____

(Official Seal) *Signature of Notary Public*

_____, Notary Public

Printed or typed name

My commission expires: _____