This

ADVANCE HEALTH CARE DIRECTIVE

prepared for

_____(Name)

Declaration

Living Will

of

_____(Name)

Pursuant to the Rights of the Terminally Ill Act, if at any time I have a terminal condition, or have lapsed into a persistent vegetative state, and if my attending physician or treating physician and another consulting physician have determined that there is no medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort, or to alleviate pain, and if I have so indicated below by initialing the provision of artificially supplied nutrition and hydration I have chosen, and by striking those provisions that I do not want to apply.

1:____ I wish to receive artificially supplied nutrition and hydration even if the effort to sustain life is futile or excessively burdensome to me.

2:____ I do not wish to receive artificially supplied nutrition and hydration, if the effort to sustain life is futile or excessively burdensome to me.

3:____ I intentionally make no decision concerning artificially supplied nutrition and hydration, leaving the decision to my Attorney-in-Fact under my duly executed Durable Power of Attorney for Health Care.

Other instructions: _____

I understand that I may revoke this declaration at any time.

It is my intention that this declaration be honored by my family and physicians as the final expression of my legal right to refuse medical or surgical treatment.

In the event that I have been determined to be unable to provide express and informed consent regarding the withholding, withdrawal, or continuation of life-prolonging procedures, my health care provider shall look to my duly executed Health Care Power of Attorney for my Attorney-in-Fact or successor Attorney-in-Fact to serve as surrogate(s) to carry out the provisions of this declaration.

In the event that I fail to designate a surrogate, or a designated surrogate cannot be located, such failure on my part will not invalidate this declaration.

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

Signed on _____(Date).

_____(Signature)
_____(NAME)
_____(City), _____(County) County, Nebraska

The declarant is known to me, is eighteen years of age or older, of sound mind and voluntarily signed this document in my presence.

_____	_____
WITNESS SIGNATURE	WITNESS SIGNATURE
_____	_____
WITNESS STREET ADDRESS	WITNESS STREET ADDRESS
_____	_____
WITNESS CITY, STATE, ZIP CODE	WITNESS CITY, STATE, ZIP CODE

STATE OF NEBRASKA)
SS
COUNTY OF _____(County))

Before me, a notary public qualified for said County, personally came _____(NAME), known to me to be the identical person who signed the foregoing instrument and acknowledged the execution thereof to be his voluntary act and deed for the purposes therein expressed.

Witness my hand and notarial seal on _____(Date).

_____
NOTARY PUBLIC SIGNATURE

NOTICE

THIS DOCUMENT MUST BE WITNESSED BY TWO ADULTS OR A NOTARY PUBLIC. NO MORE THAN ONE WITNESS TO THIS DOCUMENT SHALL BE AN ADMINISTRATOR OR EMPLOYEE OF A HEALTH CARE PROVIDER WHO IS CARING FOR OR TREATING THE DECLARANT, AND NO WITNESS SHALL BE AN EMPLOYEE OF A LIFE OR HEALTH INSURANCE PROVIDER FOR THE DECLARANT. THE RESTRICTIONS UPON WHO MAY WITNESS THE SIGNING SHALL NOT APPLY TO A NOTARY PUBLIC.

THIS DECLARATION SHALL BECOME OPERATIVE WHEN:

1. IT IS COMMUNICATED TO THE ATTENDING PHYSICIAN.

2. THE DECLARANT IS DETERMINED BY THE ATTENDING PHYSICIAN TO BE IN A TERMINAL CONDITION OR IN A PERSISTENT VEGETATIVE STATE.

3. THE DECLARANT IS DETERMINED BY THE ATTENDING PHYSICIAN TO BE UNABLE TO MAKE DECISIONS REGARDING ADMINISTRATION OF LIFE-SUSTAINING TREATMENT, AND

4. THE ATTENDING PHYSICIAN HAS NOTIFIED A REASONABLY AVAILABLE MEMBER OF THE DECLARANT'S IMMEDIATE FAMILY OR GUARDIAN, IF ANY, OF HIS OR HER DIAGNOSIS AND OF THE INTENT TO INVOKE THE PATIENT'S DECLARATION.

WHEN THE DECLARATION BECOMES OPERATIVE, THE ATTENDING PHYSICIAN AND OTHER HEALTH CARE PROVIDERS SHALL ACT IN ACCORDANCE WITH ITS PROVISIONS OR COMPLY WITH THE TRANSFER REQUIREMENTS OF NEBRASKA REV. STAT. §20-409.

THE DECLARANT MAY REVOKE A DECLARATION AT ANY TIME AND IN ANY MANNER WITHOUT REGARD TO THE DECLARANT'S MENTAL OR PHYSICAL CONDITION. A REVOCATION SHALL BE EFFECTIVE UPON ITS COMMUNICATION TO THE ATTENDING PHYSICIAN OR OTHER HEALTH CARE PROVIDER BY THE DECLARANT OR A WITNESS TO THE REVOCATION. THE ATTENDING PHYSICIAN OR OTHER HEALTH CARE PROVIDER SHALL MAKE THE REVOCATION A PART OF THE DECLARANT'S MEDICAL RECORD.

This

HEALTH CARE POWER OF ATTORNEY

prepared for

_____(NAME)

Durable Power of Attorney

for Health Care Decisions

I appoint_____(PRIMARY AGENT) with a date of birth of: _____(Primary Agent's DOB), as my Attorney-in-Fact for health care and the subsequent persons named on the following list as successors to my Spouse, in the order in which their names appear:

_____ (SUCCESSOR AGENT) DOB: _____

_____ (SUCCESSOR AGENT) DOB: _____

_____ (SUCCESSOR AGENT) DOB: _____

I authorize my Attorney-in-Fact appointed by this document to make health care decisions for me when I am determined to be incapable of making my own health care decisions. I have read the warning attached to this document and understand the consequences of executing a power of attorney for health care.

I direct that my Attorney-in-Fact comply with the following instructions or limitations:

_____

BURIAL PREPARATIONS

I direct my Attorney-in-Fact to make the following preparations:

_____

THE WITHDRAWAL OF LIFE SUPPORT

Pursuant to the Rights of the Terminally Ill Act, if at any time I have a terminal condition, or have lapsed into a persistent vegetative state, and if my attending physician or treating physician and another consulting physician have determined that there is no medical probability of my recovery from such condition, I elect the following:

1:____ That life-prolonging procedures be utilized and maintained despite the costs or burdens.

2:____ That life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort, or to alleviate pain, and I have so indicated below by initialing the provision of artificially supplied nutrition and hydration I have chosen. (#3 or #4)

3:____ I **wish** to receive artificially supplied nutrition and hydration even if the effort to sustain life is futile or excessively burdensome to me.

4:____ I **do not wish to receive** artificially supplied nutrition and hydration, if the effort to sustain life is futile or excessively burdensome to me.

5:____ I intentionally **make no decision** concerning artificially supplied nutrition and hydration, leaving the decision to my Attorney-in-Fact under my duly executed Durable Power of Attorney for Health Care.

ADMISSION TO NURSING HOMES OR COMMUNITY-BASED RESIDENTIAL FACILITIES

My health care agent may admit me to a nursing home or community-based residential facility to short-term stays, recuperative care or respite care and for long-term stays.

If I am diagnosed as mentally ill or developmentally disabled, my health care agent may admit me to a nursing home or community-based residential facility for a purpose other than recuperative care or respite care.

INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY PHYSICAL OR MENTAL HEALTH

Subject to any limitations in this document, my health care agent has the authority to do all of the following:

(a) Request, review, and receive any information, verbal or written, regarding my physical or mental health, including medical and hospital records.

(b) Execute on my behalf any documents that may be required in order to obtain this information.

(c) Consent to the disclosure of this information.

(d) Obtain written opinions from two physicians regarding my mental capacity and ability to handle my own affairs, and provide the same to my Attorney-in-Fact under my Health Care Power of Attorney.

SIGNING DOCUMENTS, WAIVERS, AND RELEASES

Where necessary to implement the health care decisions that my health care agent is authorized by this document to make, my health care agent has the authority to execute on my behalf any of the following:

(a) Documents titled or purporting to a "Consent to Permit Treatment", "Refusal to Permit Treatment" or "Leaving Hospital Against Medical Advice".

(b) A waiver or release from liability required by a hospital or physician.

I understand that I may revoke this declaration at any time.

It is my intent that this declaration be honored by my family and physicians as the final expression of my legal right to refuse medical or surgical treatment.

In the event that I have been determined to be unable to provide express informed consent regarding the withholding, withdrawal, or continuation of life-prolonging procedures, my health care provider shall look to my duly executed Health Care Power of Attorney for my Attorney-in-Fact or successor Attorney-in-Fact to serve as surrogate(s) to carry out the provisions of this declaration.

In the event that I fail to designate a surrogate, a designated surrogate cannot be located, or is unwilling to serve, such failure will not invalidate this declaration.

I HAVE READ THIS POWER OF ATTORNEY FOR HEALTH CARE. I UNDERSTAND THAT IT ALLOWS ANOTHER PERSON TO MAKE LIFE AND DEATH DECISIONS FOR ME IF I AM INCAPABLE OF MAKING SUCH DECISIONS. I ALSO UNDERSTAND THAT I CAN REVOKE THIS POWER OF ATTORNEY FOR HEALTH CARE AT ANY TIME BY NOTIFYING MY ATTORNEY-IN-FACT, MY PHYSICIAN, OR THE FACILITY IN WHICH I AM A PATIENT OR RESIDENT. I ALSO UNDERSTAND THAT I CAN REQUIRE IN THIS POWER OF ATTORNEY FOR HEALTH CARE THAT THE FACT OF MY INCAPACITY IN THE FUTURE BE CONFIRMED BY A SECOND PHYSICIAN.

_____(Signature) Date:_____

_____(NAME) (DOB: _____)

DECLARATION OF WITNESSES

We declare that the principal is personally known to us, that the principal signed or acknowledged his signature on this power of attorney for health care in our presence, that the principal appears to be of sound mind and not under duress or undue influence, and that neither of us nor the principal's attending physician is the person appointed as Attorney-in-Fact by this document.

Witnessed By:

_____ _____

(Signature of Witness) (Printed Name of Witness)

_____ _____

(Signature of Witness) (Printed Name of Witness)

STATE OF NEBRASKA)
SS
COUNTY OF _____(County_)

Before me, a notary public and for said County, personally came _____, known to me to be the identical person whose name is affixed to the above power of attorney for health care as principal, and I declare that he appears in sound mind and not under duress or undue influence, that he acknowledges that execution of the same to be his voluntary act and deed, and that I am not the Attorney-in-Fact or successor Attorney-in-Fact(s) designated by this power of attorney for health care.

Witness my hand and notarial seal on _____.

_____
NOTARY PUBLIC SIGNATURE

WARNING TO PERSON EXECUTING A POWER OF ATTORNEY FOR HEALTH CARE

This is an important legal document. It creates a power of attorney for health care. Before signing this document you should know these important facts:

(a) This document gives the person you designate as your Attorney-in-Fact the power to make health care decisions for you when you are determined to be incapable. Although not necessary and neither encouraged nor discouraged, you may wish to state instructions or wishes and limit the authority of your Attorney-in-Fact;

(b) Subject to the limitation stated in subdivision (d) of this document, the person you designate as your Attorney-in-Fact has a duty to act consistently with your desires as stated in this document or otherwise made known by you or, if your desires are unknown, to act in a manner consistent with your best interests. The person you designate in this document does, however, have the right to withdraw from this duty at any time;

(c) You may specify that any determination that you are incapable of making health care decisions must be confirmed by a second physician;

(d) The person you designate as your Attorney-in-Fact will not have the authority to consent to the withholding or withdrawal of life sustaining procedures or of artificially administered nutrition or hydration unless you give him or her that authority in this power of attorney for health care or in some other clear and convincing manner;

(e) This power of attorney for health care should be reviewed periodically. It will continue in effect indefinitely unless you exercise your right to revoke it. You have the right to revoke this power of attorney at any time while you are competent by notifying the attorney in fact or your health care provider of the revocation orally or in writing;

(f) Despite any provisions in this power of attorney for health care, you have the right to make health care decisions for yourself as long as you are not incapable of making those decisions; and

(g) If there is anything in this power of attorney for health care you do not understand, you should seek legal advice. This power of attorney for health care will not be valid for making health care decisions unless it is signed by two qualified witnesses who are personally known to you and who are present when you sign or acknowledge your signature.

Authorization to Disclose Protected Health Information

Name: _____ (DOB: _____)

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: (___) _____

Article One - Recitals and Terms

Section 1. Designation of Personal Representatives

I authorize all health care providers, including physicians, nurses, hospitals and all other persons and entities ("Covered Entities") who may have provided, or be providing, me with any type of health care, to disclose my Protected Health Information to the following parties and for the stated purposes, who shall have the status, power, authority, rights and title as my Personal Representative for all purposes as provided in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Pub. L. 104-191, 45 CFR §§ 160–164:

a. Agent under Advance Health Care Directive

The agent and successor agents, _____(Agent), _____(Successor Agent), _____(Successor Agent), AND _____(Successor Agent), in that order of succession under my advance health care directive for any health-related purpose.

b. Agent under Power of Attorney

The agent and successor agents under my durable power of attorney for property for the purpose of determining my capacity as defined in the power of attorney or by governing law.

c. Partner

To any partner of any partnership or limited liability company of which I am a partner or member for the purpose of determining my capacity as defined in the governing instrument or by governing law.

d. Attorney

To my attorney for the purposes determining my capacity to make lifetime gifts, to execute business and estate planning documents, and whether, and to what extent, a conservatorship of my person or estate or other protective proceeding is necessary or desirable.

e. Guardian Ad Litem

To my guardian ad litem, if one is appointed for me, for the purpose of determining whether, and to what extent, a conservatorship of my person or estate or other protective proceeding is necessary or desirable.

f. Receive Protected Health Information

I direct each health care provider or Covered Entity to release to my Personal Representatives any and all Protected Health Information as may be requested and deemed necessary by my Personal Representatives in order for my Personal Representative to perform his or her duties as described above.

g. Execute Releases

I authorize my Personal Representative to execute any and all releases and other documents necessary in order to obtain disclosure to my Personal Representative of my patient records and other Protected Health Information that may be subject to and protected under HIPAA.

h. Appoint Patient Advocate

I authorize my Personal Representative to appoint a Patient Advocate for me, who may be any person so designated by my Personal Representative. My Patient Advocate shall have the same right to ask questions and receive information regarding my medical condition(s), treatment, and any proposed treatment as I and my Personal Representative would have, and the right to be in attendance to me at all times.

i. Assure Compliance

I authorize my Personal Representative to take any and all legal steps to ensure compliance with my instructions to provide access to my Protected Health Information. Such steps shall include resorting to any and all legal procedures in and out of the courts as may be necessary to enforce my rights under the law and shall include attempting to recover attorney fees against anyone who does not comply with this Authorization to Disclose Protected Health Information.

Article Two - Acknowledgments

Section 1. Re-Disclosure of Protected Health Information

I understand that once my Protected Health Information is disclosed pursuant to this Authorization to Disclose Protected Health Information, it is possible that it will be no longer protected by applicable federal medical privacy regulations and could be re-disclosed by the person(s) or entity(ies) that receive it. I further understand that federal or state law may restrict re-disclosure of HIV / AIDS information, mental health information, and drug / alcohol abuse diagnosis, treatment,

or referral information. Except as deemed necessary by my Personal Representative, I do not authorize such secondary disclosure of my Protected Health Information.

Section 2. Compensation

I understand that my Personal Representative may be receiving compensation for acting in the capacity designated above and may be compensated for obtaining my Protected Health Information.

Section 3. Refusal to Sign

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain medical treatment, or payment, or eligibility for benefits. I may inspect or copy any information used or disclosed under this authorization.

Section 4. Revocation

I understand that I may revoke this authorization in writing at any time. This Authorization to Disclose Protected Health Information shall expire two years after my date of death, unless it is revoked earlier.

Article Three - General Provisions

Section 1. Effective Immediately

This Authorization Form is effective immediately.

Section 2. Expiration

This Authorization Form will continue to be effective until the sooner of its revocation by me or until two years after my death.

Section 3. Durable

This Authorization Form will continue to be effective even though I become incapacitated.

Section 4. Photocopy

A photocopy or facsimile copy of this Authorization to Disclose Protected Health Information shall have the same effect as the original.

Article Four - Execution

By signing below, I acknowledge I have read and understand this Authorization to Disclose Protected Health Information.

Date: _____ _____(Signature)

_____ (Name) (DOB_____)

STATE OF NEBRASKA)
SS
COUNTY OF _____(County))

The foregoing instrument was acknowledged before me this _____(Date) by _____(NAME).

_____
Notary Public Signature