

ADVANCE DIRECTIVES

ADVANCE DIRECTIVES OF _____ DOB: _____

To any Medical Provider who is treating me, this document contains the following information:

1. My appointment of a Health Care Representative
2. My Living Will or Health Care Instructions
3. My Document of an Anatomical Gift
4. My designation of a conservator for my future incapacity

As my medical provider you may rely on these health care instructions and decisions made by my health care representative or conservator of my person, if I am unable to make a decision for myself.

I choose not to appoint a health care representative, _____ (initial here). Please go to the next page

APPOINTMENT OF HEALTH CARE REPRESENTATIVE

I appoint _____ to be my health care representative. If my attending medical provider determines that I am unable to understand and appreciate the nature and consequences of health care decisions and unable to reach and communicate an informed decision regarding treatment, **my health care representative is authorized to (1) accept or refuse treatment, service or procedure used to diagnose or treat my physical or mental condition, except as otherwise provided by law, such as psychosurgery or shock therapy as defined by Conn. Gen. Stat. §17a-540, and (2) make the decision to provide, withhold or withdraw life support systems.**

I direct my health care representative to make decisions on my behalf in accordance with my wishes, as stated in this document or as otherwise known to my health care representative. In the event my wishes are not clear or a situation arises that I did not anticipate, my health care representative may make a decision in my best interests, based upon what is known of my wishes.

If _____ is unwilling or unable to serve as my health care representative, I appoint _____ to be my alternative health care representative.

I further instruct that as required by law my attending medical provider disclose my health care representative protected health information regarding my ability to understand and appreciate the nature and consequences of health care decisions and to reach and communicate an informed decision regarding treatment at the representative's request made at anytime after I sign this form.

These requests, appointments, and designations are made after careful reflection, while I am of sound mind. Any party receiving a duly executed copy or facsimile of this document may rely upon it unless such party has received actual notice of my revocation of it.

X _____

Date: _____

Hartford HealthCare
Medical Group 

ADVANCE DIRECTIVES

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DOCUMENT OF AN ANATOMICAL GIFT

I make no anatomical gift at this time _____ initial here

I hereby make this anatomical gift, if medically acceptable, to take effect upon my death.
_____ initial here

I give (check one): _____ (1) any needed organs or parts
_____ (2) only the following organs or part:

DESIGNATION OF A CONSERVATOR OF THE PERSON

I choose not to designate a person to be appointed as my conservator. _____ initial here

If a conservator of my person should need to be appointed, I designate _____
_____, be appointed my conservator.

If this person is unwilling or unable to serve as my conservator of my person, I designate _____
_____, be appointed my conservator. No bond shall be required of either of them in any jurisdiction.

These requests, appointment, and designation are made after careful reflection, while I am of sound mind. Any party receiving a duly executed copy or facsimile of this document may rely upon it unless such party has received actual notice of my revocation of it.

ADVANCE DIRECTIVES

ADVANCE DIRECTIVES OF _____ DOB: _____
LIVING WILL OR HEALTH CARE INSTRUCTIONS

I chose not to provide Health Care Instructions at this time, please go to next page. _____ Initial here

If the time comes when I am incapacitated to the point when I can no longer actively take part in decisions for my own life, and am unable to direct my physician as to my own medical care, I wish this statement to stand as a statement of my wishes.

I _____, the author of this document, request that, if my condition is deemed terminal or if I am determined to be permanently unconscious, I be allowed to die and not be kept alive through life support systems.

By terminal condition, I mean that I have an incurable or irreversible medical condition which, without the administration of life support systems, will, in the opinion of my attending medical provider, result in death within a relatively short time. By permanently unconscious I mean that I am in a permanent coma or persistent vegetative state which is an irreversible condition in which I am at no time aware of myself or the environment and show no behavioral response to the environment.

Specific Instructions:

Listed below are my instructions regarding particular types of life support systems. This list is not all-inclusive. My general statement that I not be kept alive through life support systems provided to me is limited only where I have indicated that I desire a particular treatment to be provided.

| | Provide | Withhold |
|---|---------|----------|
| Cardiopulmonary Resuscitation | _____ | _____ |
| Artificial Respiration (including a respirator) | _____ | _____ |
| Artificial means of providing nutrition and hydration | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Other specified requests: _____

I do want sufficient pain medication to maintain my physical comfort, I do not intend any direct taking of my life, but only that my dying is not unreasonably prolonged.



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WITNESSES' AFFIDAVITS or STATEMENT

NOTARIZATION OPTIONAL

STATE OF CONNECTICUT

Town

COUNTY OF _____

We, the subscribing witnesses, being duly sworn, say that we witnessed the execution of this appointment of a health care representative by the author of this document; that the author subscribed, published and declared the same to be the author's instructions, appointments and designation in our presence; that we thereafter subscribed the document as witnesses in the author's presence, at the author's request and in the presence of each other; that at the time of the execution of said document the author appeared to us to be eighteen years of age or older, of sound mind, able to understand the nature and consequences of said document, and under not improper influence, and we make this affidavit at the author's request this _____ day of _____, 20____.

x _____
Name

x _____
Name

x _____
Witness Signature

x _____
Witness Signature

x _____
Number and Street

x _____
Number and Street

x _____
City, State and Zip Code

x _____
City, State and Zip Code

Subscribed and sworn to before me by _____
and _____, the signing witnesses to the foregoing affidavit
this _____ day of _____, 20____.

Commissioner of the Superior Court
Notary Public

My Commission expires: _____

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