

# Advance Directives

## Helping You Control Your Health Care.

Many people have specific ideas about the kind of treatment they would like to receive in the case of a serious illness or injury. Often the people in this situation are unable to speak for themselves and make their wishes known.

Friends, family members and doctors are left to make the decisions. Sometimes they are not sure what is best or disagree on what the patient would want. Advance directives remove this burden and make sure that everyone knows how you want to be treated.

BlueCross BlueShield of Tennessee is providing information on your options and the forms required to help you and your family. Your doctor or your lawyer can give you advice on how to make these documents a part of your medical records. They need to be accessible when you need them.

You are not required by law to have any advance directives in place. It is entirely your decision.

### Living Will

Machines and medicine can keep people alive when they otherwise might die. Under the Tennessee Right to Natural Death Act, you can decide if you want to be kept alive by machines and for how long. You can do this with a “living will.”

A living will needs to be filled out while you can still think for yourself. The living will tells your friends and family how you would want your terminal illness to be treated. Your living will needs to be signed in front of two witnesses. The witnesses:

- may not be related to you by blood or marriage.
- may not be entitled to any of your belongings after you die.
- may not be your doctor or his or her employees of a health care facility where you are a patient.

One copy of your living will should be left with your doctor as part of your medical records. Another copy should be left with the person who you think would make a medical decision for you, if needed. The original copy should be with your other important papers.

Once your living will is signed and witnessed, it is your rule. It stays so unless you change your mind. As long as you can still think for yourself, you can decide about your health care without a living will.

### Durable Power of Attorney for Health Care

This document allows you to choose a person to make health care decisions for you if you are unable to speak for yourself. You can select an adult relative or close friend that you trust. It covers all health care decisions, not just life-sustaining ones, when you are unable to speak.

### Organ Donor Certification

The organ donor certification is a section within the Living Will and Durable Power of Attorney forms that will allow you to:

- Express your desire to donate all or some of your organs for transplantation; or
- State that you do not wish to donate your organs.

## Living Will

I, \_\_\_\_\_, willfully and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, and do hereby declare: If at any time I should have a terminal condition and my attending physician has determined there is no reasonable medical expectation of recovery and which, as a medical probability, will result in my death, regardless of the use or discontinuance of medical treatment implemented for the purpose of sustaining life, or the life process, I direct that medical care be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medications or the performance of any medical procedure deemed necessary to provide me with comfortable care or to alleviate pain.

Artificially Provided Nourishment and Fluids:

By checking one of the lines below, I:

\_\_\_\_\_ Authorize the withholding or withdrawal of artificially provided food, water or other nourishment or fluids.

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

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## Organ Donor Certification

Notwithstanding my previous declaration relative to the withholding or withdrawal of life-prolonging procedures, if as indicated below I have expressed my desire to donate my organs and/or tissues for transplantation, or any of them as specifically designated herein, I do direct my attending physician, if I have been determined dead according to Tennessee Code annotated, 68-3-501(b), to maintain me on artificial support systems only for the period of time required to maintain the viability of and to remove such organs and/or tissues. By checking one line below, I:

\_\_\_\_\_ Desire to donate my organs and/or tissues for transplantation.

\_\_\_\_\_ Desire to donate my \_\_\_\_\_.  
(Write specific organs and/or tissues for transplantation)

\_\_\_\_\_ DO NOT desire to donate my organs or tissues for transplantation.

In the absence of my ability to give directions regarding my medical care, it is my intention that this declaration shall be honored by my family and doctor as the final expression of my legal right to refuse medical care and accept the consequences of such refusal.

The definitions of terms used herein shall be as set forth in the Tennessee Right to Natural Death Act, Tennessee Code Annotated, 32-11-103.

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

*(continued on next page)*

**Organ Donor Certification (continued)**

In acknowledgment whereof, I do hereinafter affix my signature on this

the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.  
(Date) (Month) (Year)

\_\_\_\_\_  
(Declarant -Your Signature)

We, the subscribing witnesses hereto, are personally acquainted with and subscribe our names hereto at the request of the declarant, an adult, whom we believe to be of sound mind, fully aware of the action taken herein and its possible consequence. We, the undersigned witnesses, further declare that we are not related to the declarant by blood or marriage; that we are not entitled to any portion of the estate of the declarant upon the declarant's decease under any will or codicil thereto presently existing or by operation of law then existing; that we are not the attending physician, an employee of the attending physician or a health facility in which the declarant is a patient; and that we are not persons who, at the present time, have a claim against any portion of the estate of the declarant upon the declarant's death.

\_\_\_\_\_  
(Witness)

\_\_\_\_\_  
(Witness)

STATE OF TENNESSEE

COUNTY OF \_\_\_\_\_

Subscribed, sworn to and acknowledged before me by \_\_\_\_\_, the declarant, and subscribed and sworn to before me by \_\_\_\_\_ and \_\_\_\_\_, witnesses, this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
(Notary Public)

My Commission Expires: \_\_\_\_\_

## Tennessee Durable Power of Attorney for Health Care

If your health keeps you from making medical decisions, then this document lets another person do so for you. This person, called an agent or proxy, can state your wishes for you if you can't speak for yourself. Your illness can be temporary or reversible, such as a coma.

### WARNING TO PERSON EXECUTING THIS DOCUMENT

This is an important legal document. Before executing this document, you should know these important facts.

This document gives the person you designate as your agent (the attorney-in-fact) the power to make health care decisions for you. Your agent must act consistently with your desires as stated in this document.

Except as you otherwise specify in this document, this document gives your agent the power to consent to your doctor not giving treatment or stopping treatment necessary to keep you alive.

Notwithstanding this document, you have the right to make medical and other health care decisions for yourself so long as you can give informed consent with respect to the particular decision. In addition, no treatment may be given to you over your objections, and health care necessary to keep you alive may not be stopped or withheld if you object at the time.

This document gives your agent authority to consent, to refuse to consent, or to withdraw consent to any care, treatment, service, or procedure to maintain, diagnose or treat a physical or mental condition. This power is subject to any limitations that you include in this document. You may state in this document any types of treatment that you do not desire. In addition, a court can take away the power of your agent to make health care decisions for you if your agent: (1) authorizes anything that is illegal, or (2) acts contrary to your desires as stated in this document.

You have the right to revoke the authority of your agent by notifying your agent or your treating physician, hospital or other health care provider orally or in a writing of the revocation.

Your agent has the right to examine your medical records and to consent to their disclosure unless you limit this right in this document.

Unless you otherwise specify in this document, this document gives your agent the power after you die to: (1) authorize an autopsy, (2) donate your body or parts thereof for transplant or therapeutic, educational or specific purposes, and (3) direct the disposition of your remains.

If there is anything in this document that you do not understand, you should ask a lawyer to explain it to you.

I hereby appoint\* \_\_\_\_\_ as my attorney-in-fact to make healthcare decisions for me, if, and only if, I am incapacitated or otherwise unable to make such decisions for myself.

My attorney-in-fact has received an executed copy of this document, and has agreed to serve as my attorney-in-fact for healthcare decisions consistent with my directions herein expressed.

If, at any time, I should have a terminal condition, or be in an irreversible coma or permanent vegetative state, and my attending physician or other health care provider has determined that there can be no

recovery from such condition or state, where the application of medical treatment implemented for the purpose of sustaining life, or the life process would serve only artificially to prolong the dying process, my attorney-in-fact is specifically directed to direct that such medical treatment be withheld or withdrawn, and that I be permitted to die naturally, with only the administration of medications or the performance of any medical procedure deemed necessary to provide me with comfortable care, or to alleviate pain.

ARTIFICIALLY PROVIDED NOURISHMENT AND FLUIDS: By checking the appropriate line below, I specifically:

\_\_\_\_\_ Authorize the withholding or withdrawal of artificially provided food, water, or other nourishment or fluids.

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

ORGAN/TISSUE DONATION: My attorney-in-fact shall have full authority to donate all or any part of my body, authorize an autopsy and direct the disposition of my remains. By checking the line below, I specifically:

\_\_\_\_\_ Desire to donate my organs and/or tissues for transplantation.

\_\_\_\_\_ Desire to donate my \_\_\_\_\_  
(indicate specific organs and/or tissues for transplantation.)

\_\_\_\_\_ DO NOT desire to donate my organs or tissues for transplantation.

My attorney-in-fact shall have the right to examine my medical records and to consent to their disclosure. I grant to my attorney-in-fact the power and authority to execute on my behalf any waiver, release or other document which may be necessary in order to implement the health care decisions that this instrument authorizes my attorney-in-fact to make on my behalf.

In the event the above-named attorney-in-fact should for any reason be unable or unwilling to serve as my attorney-in-fact under this instrument, I appoint\* \_\_\_\_\_  
\_\_\_\_\_ to serve in such capacity. This individual also has been furnished with a copy of this document, and has agreed to serve as my alternative attorney-in-fact.

This instrument is to be construed and interpreted as a durable power of attorney for health care and is intended to comply in all respects with the provisions of Tennessee Code Annotated, Sections 34-6-201 et seq.: and all terms used in this instrument shall have the meanings set forth for such items in the statute, unless otherwise specifically defined herein. This durable power of attorney for health care revokes any prior durable powers of attorney for health care executed by me.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 2003

\_\_\_\_\_  
Signature of Principal

*\*Print name, address, and telephone number*

We, the undersigned witnesses, declare under penalty of perjury under the laws of Tennessee, that \_\_\_\_\_ is personally known to us to be the principal; that the principal signed and acknowledged this Durable Power of Attorney for Health Care in our presence; that the principal appears to be of sound mind and under no duress, fraud, or undue influence; that neither of us is the person appointed as attorney-in-fact by this instrument; and that neither of us is a health care provider, an employee of a health care provider, the operator of a health care institution, or an employee of an operator of a health care institution. We further declare under penalty of perjury under the laws of Tennessee that we are not related to the principal by blood, marriage, or adoption; and that, to the best of our knowledge, we are not entitled to any part of the principal's estate upon the death of the principal under any will or codicil of the principal existing as of the date of this instrument, or by operation of an existing law.

STATE OF TENNESSEE

COUNTY OF \_\_\_\_\_

On this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_, before the undersigned Notary Public, personally appeared \_\_\_\_\_, personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this instrument, and acknowledged that \_\_\_\_\_ executed it. I declare under penalty of perjury that the person whose name is subscribed to this instrument appears to be of sound mind and under no duress, fraud or undue influence.



**of Tennessee**  
plans for better health. plans for a better life.™

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P.O. Box 180205  
Chattanooga, TN 37402

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