PENINSULA
Dermatology
SKIN CANCER SURGERY CENTER

VIRGINIA ADVANCE DIRECTIVE FOR HEALTH CARE

I, _____, willingly and voluntarily make known
Printed Name of Individual Making This Advance Directive for Health Care (Declarant)
my wishes in the event that I am incapable of making an informed decision about my health care, as follows:

APPOINTMENT AND POWERS OF MY AGENT

(CROSS THROUGH THIS SECTION I IF YOU DO NOT WANT TO APPOINT AN AGENT TO MAKE HEALTH CARE DECISIONS FOR YOU.)

A. Appointment of My Agent

I hereby appoint _____
Name of Primary Agent — Email Address

_____
Home Address — Telephone Number

as my agent to make health care decisions on my behalf as authorized in this document. If the primary agent named above is not reasonably available or is unable or unwilling to act as my agent, then I appoint a successor agent to serve in that capacity:

_____
Name of Successor Agent — E-mail Address

_____
Home Address — Telephone Number

I grant to my agent full authority to make health care decisions on my behalf as described below. My agent shall have this authority whenever and for as long as I have been determined to be incapable of making an informed decision.

In making health care decisions on my behalf, I want my agent to follow my desires and preferences as stated in this document or as otherwise known to him or her. If my agent cannot determine what health care choice I would have made on my own behalf, then I want my agent to make a choice for me based upon what he or she believes to be in my best interests.

B. Powers of My Agent

[IF YOU APPOINTED AN AGENT ABOVE, YOU MAY GIVE HIM/HER THE POWERS SUGGESTED BELOW. YOU MAY CROSS THROUGH ANY POWERS LISTED BELOW THAT YOU DO NOT WANT TO GIVE YOUR AGENT AND ADD ANY ADDITIONAL POWERS YOU DO WANT TO GIVE YOUR AGENT.] The powers of my agent shall include the following:

1. To consent to or refuse or withdraw consent to any type of health care, including, but not limited to, artificial respiration (breathing machine), artificially administered nutrition (tube feeding) and hydration (IV fluids), and cardiopulmonary resuscitation (CPR). This authorization specifically includes the power to consent to dosages of pain-relieving medication in excess of recommended dosages in an amount sufficient to relieve pain. This applies even if this medication carries the risk of addiction or of inadvertently hastening my death.
2. To request, receive and review any oral or written information regarding my physical or mental health, including but not limited to medical and hospital records, and to consent to the disclosure of this information as necessary to carry out my directions as stated in this advance directive.
3. To employ and discharge my health care providers.

4. To authorize my admission, transfer, or discharge to or from a hospital, hospice, nursing home, assisted living facility or other medical care facility.
5. To authorize my admission to a health care facility for treatment of mental illness as permitted by law. (If I have other instructions for my agent regarding treatment for mental illness, they are stated in a supplemental document.)
6. To continue to serve as my agent if I object to the agent's authority after I have been determined to be incapable of making an informed decision.
7. To authorize my participation in any health care study approved by an institutional review board or research review committee according to applicable federal or state law if the study offers the prospect of direct therapeutic benefit to me.
8. To authorize my participation in any health care study approved by an institutional review board or research review committee according to applicable federal or state law that aims to increase scientific understanding of any condition that I may have or otherwise to promote human well-being, even though it offers no prospect of direct benefit to me.
9. To make decisions regarding visitation during any time that I am admitted to any health care facility, consistent with the following directions:

_____

10. To take any lawful actions that may be necessary to carry out these decisions, including the granting of releases of liability to medical providers.

AFFIRMATION AND RIGHT TO REVOKE: By signing below, I indicate that I understand this document and that I am willingly and voluntarily executing it. I also understand that I may revoke all or any part of it at any time as provided by law. ***This supersedes all previous directives.***

_____

Date **Signature of Declarant**

The declarant signed the foregoing advance directive in my presence. *[TWO ADULT WITNESSES NEEDED]*

_____

Witness Signature **Witness Printed**

_____

Witness Signature **Witness Printed**