State of Wisconsin

Department of Health Services

Instructions to Complete the Power of Attorney for Health Care Form

To Whom It May Concern:

Enclosed is the Power of Attorney for Health Care form you requested. The Power of Attorney for Health Care form makes it possible for adults in Wisconsin to authorize other individuals (called health care agents) to make health care decisions on their behalf should they become incapacitated. It may also be used to make or refuse to make an anatomical gift (donation of all or part of the human body to take effect upon the death of the donor).

Be sure to read all six (6) pages of the form carefully and understand it before you complete and sign it. Talk with those you select as your health care agent and the alternate health care agent about your thoughts and beliefs about medical treatment. Neither the health care agent nor the alternate may be your health care provider, an employee of a health care facility in which you are a patient, or a spouse of any of those persons, unless he or she is also your relative.

Two witnesses are required. Witnesses must be at least 18 years of age, not related to you by blood, marriage, domestic partnership, or adoption, and not directly financially responsible for your health care. A witness cannot be a health care provider who is serving you at the time the document is signed or an employee of the health care provider unless the employee is a chaplain or social worker. A witness cannot be an employee of an inpatient health care facility in which you are a patient, unless the employee is a chaplain or social worker. A witness cannot be your health care agent nor have a claim on any portion of your estate. Valid witnesses acting in good faith are immune from civil or criminal liability.

An original signed form may be kept on file with your physician or other primary care provider. A signed Power of Attorney for Health Care form may also be kept in a safe, easily accessible place until needed. You should make relatives and friends aware that you have created a Power of Attorney for Health Care and the location where it is kept. Relatives and friends should also be told whom you select as the health care agent and the alternate. The document may, but is not required to be, filed for safekeeping, for a fee, with the Register in Probate of your county of residence. The fee for filing with the Register in Probate has been set by State Statute at $8.00. A Power of Attorney for Health Care that is an original signed form or is a legible photocopy or electronic facsimile copy is presumed to be valid. If you have both a Power of Attorney for Health Care and a Declaration to Physicians, the provisions of a valid Power of Attorney for Health Care supersede any directly conflicting provisions of a valid Declaration to Physicians.

One copy of the Power of Attorney for Health Care form is available free to anyone who sends a stamped, self-addressed, business-size envelope to: Power of Attorney, Division of Public Health, P.O. Box 2659, Madison, Wisconsin 53701-2659. You may make additional blank copies of the form you receive from the Division of Public Health. The form is also available on the Department of Health Services Web page, https://www.dhs.wisconsin.gov/forms/advdirectives/index.htm.

Definitions 'Department' means the Department of Health Services. 'Health Care' means any care, treatment, service, or procedure to maintain, diagnose, or treat an individual's physical or mental condition. 'Health care decision' means an informed decision in the exercise of the right to accept, maintain, discontinue, or refuse health care. 'Health care facility' means a facility, as defined in State Statute 647.01(4), or any hospital, nursing home, community-based residential facility, county home, county infirmary, county hospital, county mental health center, tuberculosis sanatorium or other place licensed or approved by the department under State Statutes 49.70, 49.71, 49.72, 50.02, 50.03, 50.35, 51.08, 51.09, 58.06, 252.073 or 252.076 or a facility under §§ 45.365, 51.05, 51.06, 233.40, 233.41. 233.42 or 252.10. 'Health care provider' means a nurse licensed or permitted under State Statute Chapter 441, a chiropractor licensed under Chapter 446, a dentist licensed under Chapter 447, a physician, podiatrist or physical therapist licensed or an occupational therapist or occupational therapy assistant certified under Chapter 448, a person practicing Christian Science treatment, an optometrist licensed under Chapter 449, a psychologist licensed under

Chapter 455, a partnership thereof, a corporation thereof that provides health care services, an operational cooperative sickness care plan organized under State Statute 185.981 to 185.985 that directly provides services through salaried employees in its own facility, or a home health agency, as defined in State Statute 50.49 (1) (a). 'Incapacity' means the inability to receive and evaluate information effectively or to communicate decisions to such an extent that the individual lacks the capacity to manage his or her health care decisions. 'Feeding tube' means a medical tube through which nutrition or hydration is administered into the vein, stomach, nose, mouth or other body opening of the declarant.

Who may sign a Power of Attorney for Health Care? An individual who is of sound mind and has attained age 18 may voluntarily execute a Power of Attorney for Health Care. An individual for whom an adjudication of incompetence and appointment of a guardian of the person is in effect under State Statute Chapter 54 is presumed not to be of sound mind.

Procedure for signing a Power of Attorney for Health Care The principal (person creating the Power of Attorney for Health Care) and the witnesses all must sign the form at the same time.

When does it take effect? Unless otherwise specified in the Power of Attorney for Health Care instrument (form), an individual's Power of Attorney for Health Care takes effect upon a finding of incapacity by 2 physicians, or a physician and a psychologist, as defined in State Statute 448.01 (5), or nurse practitioner, or physician assistant who personally examine the principal and sign a statement specifying that the principal has incapacity. Mere old age, eccentricity, or physical disability, either singly or together, is insufficient to make a finding of incapacity. Neither of the individuals who make a finding of incapacity may be a relative of the principal nor have knowledge that he or she is entitled to or has a claim on any portion of the principal's estate. A copy of the statement, if made, shall be appended to the Power of Attorney for Health Care instrument.

Revocation A principal may revoke his or her Power of Attorney for Health Care and invalidate the Power of Attorney for Health Care instrument at any time by doing any of the following: canceling, defacing, obliterating, burning, tearing or otherwise destroying the Power of Attorney for Health Care instrument or directing another in the presence of the principal to so destroy the Power of Attorney for Health Care instrument; executing a statement, in writing, that is signed and dated by the principal, expressing the principal's intent to revoke the Power of Attorney for Health Care; verbally expressing the principal's intent to revoke the Power of Attorney for Health Care in the presence of 2 witnesses; or, executing a subsequent Power of Attorney for Health Care instrument. The principal's health care provider shall, upon notification of revocation of the principal's Power of Attorney for Health Care instrument, record in the principal's medical record the time, date and place of the revocation and the time, date and place, if different, of the notification to the health care provider of the revocation.

Immunities No health care facility or health care provider may be charged with a crime, held civilly liable, or charged with unprofessional conduct for any of the following: certifying incapacity under State Statute 155.05 (2), if the certification is made in good faith based on a thorough examination of the principal; failing to comply with a Power of Attorney for Health Care instrument or the decision of a health care agent, except that failure of a physician to comply constitutes unprofessional conduct if the physician refuses or fails to make a good faith attempt to transfer the principal to another physician who will comply; complying, in the absence of actual knowledge of a revocation, with the terms of a Power of Attorney for Health Care instrument that is in compliance with Chapter 155; complying with the decision of a health care agent that is made under a Power of Attorney for Health Care that is in compliance with Chapter 155; acting contrary to or failing to act on a revocation of a Power of Attorney for Health Care, unless the health care facility or health care provider has actual knowledge of the revocation; or, failing to obtain the health care decision for a principal from the principal's health care agent, if the health care facility or health care provider has made a reasonable attempt to contact the health care agent and obtain the decision but has been unable to do so. No health care agent may be charged with a crime or held civilly liable for making a decision in good faith under a Power of Attorney for Health Care instrument that is in compliance with Chapter 155. No health care agent who is not the spouse of the principal may be held personally liable for any goods or services purchased or contracted for under a Power of Attorney for Health Care instrument.

General provisions The making of a health care decision on behalf of a principal under the principal's Power of Attorney for Health Care instrument does not, for any purpose, constitute suicide. No individual may be required to execute a Power of Attorney for Health Care as a condition for receipt of health care or admission to a health care facility. No insurer may refuse to pay for goods or services covered under a principal's insurance policy solely because the decision to use the goods or services was made by the principal's health care agent.

Important:
You must keep pages 1-6 of the form together as your executed document. Copies distributed to health care providers, etc. must include pages 1 - 6.

POWER OF ATTORNEY FOR HEALTH CARE DOCUMENT
NOTICE TO PERSON MAKING THIS DOCUMENT

You have the right to make decisions about your health care. No health care may be given to you over your objection, and necessary health care may not be stopped or withheld if you object.

Because your health care providers in some cases may not have had the opportunity to establish a long-term relationship with you, they are often unfamiliar with your beliefs and values and the details of your family relationships. This poses a problem if you become physically or mentally unable to make decisions about your health care.

In order to avoid this problem, you may sign this legal document to specify the person whom you want to make health care decisions for you if you are unable to make those decisions personally. That person is known as your health care agent. You should take some time to discuss your thoughts and beliefs about medical treatment with the person or persons whom you have specified. You may state in this document any types of health care that you do or do not desire, and you may limit the authority of your health care agent. If your health care agent is unaware of your desires with respect to a particular health care decision, he or she is required to determine what would be in your best interests in making the decision.

This is an important legal document. It gives your agent broad powers to make health care decisions for you. It revokes any prior power of attorney for health care that you may have made. If you wish to change your power of attorney for health care, you may revoke this document at any time by destroying it, by directing another person to destroy it in your presence, by signing a written and dated statement or by stating that it is revoked in the presence of two witnesses. If you revoke, you should notify your agent, health care provider(s), and any other person(s) to whom you have given a copy. If your agent is your spouse or your domestic partner, and your marriage is annulled or you are divorced or your domestic partnership is terminated after signing this document, the document is invalid.

You may also use this document to make or refuse to make an anatomical gift upon your death. If you use this document to make or refuse to make an anatomical gift, this document revokes any prior record of gift that you may have made. You may revoke or change any anatomical gift that you make by this document by crossing out the anatomical gifts provision in this document.

Do not sign this document unless you clearly understand it. It is suggested that you keep the original of this document on file with your physician or other primary care provider.

POWER OF ATTORNEY FOR HEALTH CARE

Document made this _____ day of _____ (month), _____ (year).

CREATION OF POWER OF ATTORNEY FOR HEALTH CARE

I, _____

_____

_____

_____

(print name, address, and date of birth),

being of sound mind, intend by this document to create a power of attorney for health care. My executing this power of attorney for health care is voluntary. Despite the creation of this power of attorney for health care, I expect to be fully informed about and allowed to participate in any health care decision for me, to the extent that I am able. For the purposes of this document, "health care decision" means an informed decision to accept, maintain, discontinue, or refuse any care, treatment, service, or procedure to maintain, diagnose, or treat my physical or mental condition.

In addition, I may, by this document, specify my wishes with respect to making an anatomical gift upon my death.

DESIGNATION OF HEALTH CARE AGENT

If I am no longer able to make health care decisions for myself, due to my incapacity,

I hereby designate _____

_____

(print name, address and telephone number) to be my health care agent for the purpose of making health care decisions on my behalf. If he or she is ever unable or unwilling to do so,

I hereby designate _____

_____

(print name, address and telephone number)

to be my alternate health care agent for the purpose of making health care decisions on my behalf. Neither my health care agent nor my alternate health care agent whom I have designated is my health care provider, an employee of my health care provider, an employee of a health care facility in which I am a patient or a spouse of any of those persons, unless he or she is also my relative. For purposes of this document, "incapacity" exists if 2 physicians or a physician and a psychologist, nurse practitioner, or physician assistant who have personally examined me sign a statement that specifically expresses their opinion that I have a condition that means that I am unable to receive and evaluate information effectively or to communicate decisions to such an extent that I lack the capacity to manage my health care decisions. A copy of that statement must be attached to this document.

GENERAL STATEMENT OF AUTHORITY GRANTED

Unless I have specified otherwise in this document, if I ever have incapacity I instruct my health care provider to obtain the health care decision of my health care agent, if I need treatment, for all of my health care and treatment. I have discussed my desires thoroughly with my health care agent and believe that he or she understands my philosophy regarding the health care decisions I would make if I were able. I desire that my wishes be carried out through the authority given to my health care agent under this document.

If I am unable, due to my incapacity, to make a health care decision, my health care agent is instructed to make the health care decision for me, but my health care agent should try to discuss with me any specific proposed health care if I am able to communicate in any manner, including by blinking my eyes. If this communication cannot be made, my health care agent shall base his or her decision on any health care choices that I have expressed prior to the time of the decision. If I have not expressed a health care choice about the health care in question and communication cannot be made, my health care agent shall base his or her health care decision on what he or she believes to be in my best interest.

LIMITATIONS ON MENTAL HEALTH TREATMENT

My health care agent may not admit or commit me on an inpatient basis to an institution for mental diseases, an intermediate care facility for the persons with intellectual disability, a state treatment facility, or a treatment facility. My health care agent may not consent to experimental mental health research or psychosurgery, electroconvulsive treatment or drastic mental health treatment procedures for me.

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 for short-term stays for recuperative care or respite care.

If I have checked "Yes" to the following, my health care agent may admit me for a purpose other than recuperative care or respite care, but if I have checked "No" to the following, my health care agent may not so admit me:

1. A nursing home Yes ☐ No ☐
2. A community-based residential facility Yes ☐ No ☐

If I have not checked either "Yes" or "No" immediately above, my health care agent may admit me only for short-term stays for recuperative care or respite care.

PROVISION OF FEEDING TUBE

If I have checked "Yes" to the following, my health care agent may have a feeding tube withheld or withdrawn from me, unless my physician, physician assistant, or nurse practioner has advised that, in his or her professional judgment, this will cause me pain or will reduce my comfort. If I have checked "No" to the following, my health care agent may not have a feeding tube withheld or withdrawn from me.

My health care agent may not have orally ingested nutrition or hydration withheld or withdrawn from me unless provision of the nutrition or hydration is medically contraindicated.

Withhold or withdraw a feeding tube Yes ☐ No ☐

If I have not checked either "Yes" or "No" immediately above, my health care agent may not have a feeding tube withdrawn from me.

HEALTH CARE DECISIONS FOR PREGNANT WOMEN

If I have checked "Yes" to the following, my health care agent may make health care decisions for me even if my agent knows I am pregnant. If I have checked "No" to the following, my health care agent may not make health care decisions for me if my health care agent knows I am pregnant.

Health care decision if I am pregnant Yes ☐ No ☐

If I have not checked either "Yes" or "No" immediately above, my health care agent may not make health care decisions for me if my health care agent knows I am pregnant.

STATEMENT OF DESIRES, SPECIAL PROVISIONS OR LIMITATIONS

In exercising authority under this document, my health care agent shall act consistently with my following stated desires, if any, and is subject to any special provisions or limitations that I specify. The following are any specific desires, provisions or limitations that I wish to state (add more items if needed):

1. _____

2. _____

3. _____

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, oral 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.

(The principal and the witnesses all must sign the document at the same time.)

SIGNATURE OF PRINCIPAL

(Person creating the Power of Attorney for Health Care)

Signature _____ Date _____

(The signing of this document by the principal revokes all previous powers of attorney for health care documents.)

STATEMENT OF WITNESSES

I know the principal personally and I believe him or her to be of sound mind and at least 18 years of age. I believe that his or her execution of this power of attorney for health care is voluntary. I am at least 18 years of age, am not related to the principal by blood, marriage, domestic partnership, or adoption, and am not directly financially responsible for the principal's health care. I am not a health care provider who is serving the principal at this time, an employee of the health care provider, other than a chaplain or a social worker, or an employee, other than a chaplain or a social worker, of an inpatient health care facility in which the declarant is a patient. I am not the principal's health care agent. To the best of my knowledge, I am not entitled to and do not have a claim on the principal's estate.

Witness Number 1

(Print) Name _____ Date _____

Address _____

Signature _____

Witness Number 2

(Print) Name _____ Date _____

Address _____

Signature _____

STATEMENT OF HEALTH CARE AGENT AND ALTERNATE HEALTH CARE AGENT

I understand that _____ (name of principal) has designated me to be his or her health care agent or alternate health care agent if he or she is ever found to have incapacity and unable to make health care decisions himself or herself

_____(name of principal)

has discussed his or her desires regarding health care decisions with me.

Agent's Signature _____

Address _____

Alternate's Signature _____

Address _____

Failure to execute a power of attorney for health care document under chapter 155 of the Wisconsin Statutes creates no presumption about the intent of any individual with regard to his or her health care decisions. This power of attorney for health care is executed as provided in chapter 155 of the Wisconsin Statutes.

ANATOMICAL GIFTS (optional)
Upon my death:

☐ I wish to donate only the following organs or parts: (specify the organs or parts).

_____

_____

_____

☐ I wish to donate any needed organ or part.

☐ I wish to donate my body for anatomical study if needed.

☐ I refuse to make an anatomical gift. (If this revokes a prior commitment that I have made to make an anatomical gift to a designated donee, I will attempt to notify the donee to which or to whom I agreed to donate.)

Failing to check any of the lines immediately above creates no presumption about my desire to make or refuse to make an anatomical gift.

Signature _____ Date _____

F-00085 (Rev. 02/2020)

State of Wisconsin

Department of Health Services

The Declaration to Health Care Professionals (Living Will) form makes it possible for adults in Wisconsin to state their preferences for life-sustaining procedures and feeding tubes in the event, the person is in a terminal condition or persistent vegetative state.

Be sure to read both sides of the form carefully, and understand before you complete and sign it.

The withholding or withdrawal of any medication, life-sustaining procedure or feeding tube may not be made if the attending physician, physician assistant, or advanced practice registered nurse advises that doing so will cause pain or reduce comfort, and the pain or discomfort cannot be alleviated through pain relief measures.

Two witnesses are required. Witnesses must be at least 18 years of age, not related to you by blood, marriage or adoption, and not directly financially responsible for your health care. Witnesses may not be persons who know they are entitled to or have a claim on any portion of your estate. A witness cannot be a health care provider who is serving you at the time the document is signed, an employee of the health care provider, other than a chaplain or a social worker, or an employee other than a chaplain or social worker of an inpatient health care facility in which you are a patient. Valid witnesses acting in good faith are immune from civil or criminal liability.

When you have completed and signed the form:

- The original signed form should be kept in a safe, easily accessible place until needed.
- You should make relatives and friends aware that you have signed the document and the location where it is kept.
- A copy of the signed form may be kept on file with your physician, physician assistant, or advanced practice registered nurse. You are responsible for notifying your attending physician, physician assistant, or advanced practice registered nurse of the existence of the Declaration. An attending physician, physician assistant or advanced practice registered nurse who is notified shall make the Declaration part of your medical records.
- The document may, but is not required to be, filed for safekeeping, for a fee, with the Register in Probate of your county of residence. The fee for filing with the Register in Probate has been set by State at $8.

A Declaration that is in its original form or is a legible photocopy or electronic facsimile copy is presumed to be valid.

If you have both a Declaration to Health Care Professionals and a Power of Attorney for Health Care, the provisions of a valid Power of Attorney for Health Care supersede any directly conflicting provisions of a valid Declaration to Health Care Professionals.

Up to four copies of the Declaration to Health Care Professionals are available free to anyone who sends a stamped, self-addressed, business-size envelope to Living Will, Division of Public Health, PO Box 2659, Madison, Wisconsin 53701-2659. You may make additional copies of the enclosed blank form. The form is also available on the Department of Health Services Web page https://www.dhs.wisconsin.gov/forms/advdirectives/index.htm.

INSTRUCTIONS FOR DECLARATION TO HEALTH CARE PROFESSIONALS FORM

Definitions

"Declaration" means a written, witnessed document voluntarily executed by the declarant under State Statute (1), but is not limited in form or substance to that provided in State Statute 154.03(2).

"Department" means the Department of Health Services.

"Feeding tube" means a medical tube through which nutrition or hydration is administered into the vein, stomach, nose, mouth or other body opening of a qualified patient.

"Terminal condition" means an incurable condition caused by injury or illness that reasonable medical judgment finds would cause death imminently, so that the application of life-sustaining procedures serves only to postpone the moment of death.

"Persistent vegetative state" means a condition that reasonable, medical judgment finds constitutes complete and irreversible loss of all the functions of the cerebral cortex and results in a complete, chronic and irreversible cessation of all cognitive functioning and consciousness and a complete lack of behavioral responses that indicate cognitive functioning, although autonomic functions continue.

"Qualified patient" means a declarant who has been diagnosed, and certified in writing to be afflicted with a terminal condition or to be in a persistent vegetative state by two health care professionals and one of whom is a physician, who have personally examined the declarant.

"Attending health care professional" means a health care professional who has primary responsibility for the treatment and care of the patient.

"Advanced practice registered nurse" means a nurse licensed under ch. 154 who is currently certified by a national certifying body approved by the board of nursing as a nurse practitioner, certified midwife, certified registered nurse anesthetist, or clinical nurse specialist.

"Health care professional" means any of the following: a physician licensed under ch. 154, a physician assistant licensed under ch. 154, or an advanced practice registered nurse.

"Inpatient health care facility" has the meaning provided under State Statute 50.135(1) and includes community-based residential facilities as defined in State Statute 50.01(1g).

"Life-sustaining procedure" means any medical procedure or intervention that, in the judgment of the attending health care professional, would serve only to prolong the dying process but not avert death when applied to a qualified patient.

"Life-sustaining procedure" includes assistance in respiration, artificial maintenance of blood pressure and heart rate, blood transfusion, kidney dialysis and other similar procedures, but does not include (a) the alleviation of pain by administering medication or by performing a medical procedure; or (b) the provision of nutrition or hydration.

Procedures for Signing Declarations

A Declaration must be signed by the declarant in the presence of two witnesses. If the declarant is physically unable to sign a Declaration, the Declaration must be signed in the declarant's name by one of the witnesses or some other person at the declarant's express direction and in his or her presence; such a proxy signing shall either take place or be acknowledged by the declarant in the presence of two witnesses.

Effect of Declaration

The desires of a qualified patient who is competent supersede the effect of the Declaration at all times. If a qualified patient is incompetent at the time of the decision to withhold or withdraw life-sustaining procedures or feeding tubes, a Declaration executed under this chapter is presumed to be valid.

Revocation of Declaration

A Declaration may be revoked at any time by the declarant by any of the following methods:

1) By being canceled, defaced, obliterated, burned, torn or otherwise destroyed by the declarant or by some person who is directed by the declarant and who acts in the presence of the declarant.
2) By a written revocation, signed and dated by the declarant expressing the intent to revoke.
3) By a verbal expression by the declarant of his or her intent to revoke the Declaration, but only if the declarant or a person acting on behalf of the declarant notifies the attending physician, physician assistant, or advanced practice registered nurse of the revocation.
4) By executing a subsequent Declaration.

The attending physician, physician assistant, or advanced practice registered nurse shall record in the declarant's medical records the time, date and place of the revocation and time, date and place, if different, that he or she was notified of the revocation.

Liabilities

No physician, physician assistant, or advanced practice registered nurse, inpatient health care facility or health care professional acting under direction of a physician, physician assistant, or advanced practice registered nurse may be held criminally or civilly liable, or charged with unprofessional conduct of any of the following:

1) Participating in the withholding or withdrawal of life-sustaining procedures or feeding tubes under Ch. 154, subchapter II.
2) Failing to act upon a revocation unless the person or facility has actual knowledge of the revocation.
3) Failing to comply with a Declaration, except that failure by a physician, physician assistant, or advanced practice registered nurse to comply with a Declaration of a qualified patient constitutes unprofessional conduct if the physician, physician assistant, or advanced practice registered nurse refuses or fails to make a good faith attempt to transfer the patient to another physician, physician assistant, or advanced practice registered nurse who will comply with the Declaration.

PLEASE BE SURE YOU READ THE FORM CAREFULLY AND UNDERSTAND IT BEFORE YOU COMPLETE AND SIGN IT

DECLARATION TO HEALTH CARE PROFESSIONALS (WISCONSIN LIVING WILL)

I, _____

being of sound mind, voluntarily state my desire that my dying not be prolonged under the circumstances specified in this document. Under those circumstances, I direct that I be permitted to die naturally. If I am unable to give directions regarding the use of life-sustaining procedures or feeding tubes, I intend that my family and physician, physician assistant or advanced practice registered nurse, honor this document as the final expression of my legal right to refuse medical or surgical treatment.

1. If I have a **TERMINAL CONDITION**, as determined by a physician, physician assistant, or advanced practice registered nurse, who have personally examined me, and if a physician who has also personally examined me agrees with that determination, I do not want my dying to be artificially prolonged and I do not want life-sustaining procedures to be used. In addition, the following are my directions regarding the use of feeding tubes:

   ☐ YES, I want feeding tubes used if I have a terminal condition.

   ☐ NO, I do not want feeding tubes used if I have a terminal condition.

   If you have not checked either box, feeding tubes will be used.

2. If I am in a **PERSISTENT VEGETATIVE STATE**, as determined by a physician, physician assistant, or advanced practice registered nurse who have personally examined me, and if a physician who has also personally examined me agrees with that determination, the following are my directions regarding the use of life-sustaining procedures:

   ☐ YES, I want life-sustaining procedures used if I am in a persistent vegetative state.

   ☐ NO, I do not want life-sustaining procedures used if I am in a persistent vegetative state.

   If you have not checked either box, life-sustaining procedures will be used.

3. If I am in a **PERSISTENT VEGETATIVE STATE**, as determined by a physician, physician assistant, or advanced practice registered nurse who has personally examined me, and if a physician who has also personally examined me agrees with that determination, the following are my directions regarding the use of feeding tubes:

   ☐ YES, I want feeding tubes used if I am in a persistent vegetative state.

   ☐ NO, I do not want feeding tubes used if I am in a persistent vegetative state.

   If you have not checked either box, feeding tubes will be used.

If you are interested in more information about the significant terms used in this document, see section 154.01 of the Wisconsin Statutes or the information accompanying this document.

ATTENTION: You and the 2 witnesses must sign the document at the same time.

Signed_____ **Date**_____

Address_____ **Date of Birth**_____

I believe that the person signing this document is of sound mind. I am an adult and am not related to the person signing this document by blood, marriage or adoption. I am not entitled to and do not have a claim on any portion of the person's estate and am not otherwise restricted by law from being a witness.

Witness **Signature**_____ **Date Signed**_____

Print Name_____

Witness **Signature**_____ **Date Signed** _____

Print Name_____

DIRECTIVES TO ATTENDING PHYSICIAN, PHYSICIAN ASSISTANT, OR ADVANCED PRACTICE REGISTERED NURSE

1. This document authorizes the withholding or withdrawal of life-sustaining procedures or of feeding tubes when a physician and another physician, physician assistant, or advanced practice registered nurse, one of whom is the attending health care professional, have personally examined and certified in writing that the patient has a terminal condition or is in a persistent vegetative state.

2. The choices in this document were made by a competent adult. Under the law, the patient's stated desires must be followed unless you believe that withholding or withdrawing life-sustaining procedures or feeding tubes would cause the patient pain or reduced comfort and that the pain or discomfort cannot be alleviated through pain relief measures. If the patient's stated desires are that life-sustaining procedures or feeding tubes be used, this directive must be followed.

3. If you feel that you cannot comply with this document, you must make a good faith attempt to transfer the patient to another physician, physician assistant, or advanced practice registered nurse who will comply. Refusal or failure to make a good faith attempt to do so constitutes unprofessional conduct.

4. If you know that the patient is pregnant, this document has no effect during her pregnancy.

* * * * *

The person making this living will may use the following space to record the names of those individuals and health care providers to whom he or she has given copies of this document:

_____

_____

_____

_____

HIPAA COLLABORATIVE OF WISCONSIN
AUTHORIZATION FOR USE & DISCLOSURE OF HEALTH INFORMATION

[Individual/Patient/Client/Insured]:

Name of Patient/Previous Names _____ Birth Date _____

Street Address _____ City, State, Zip, Phone _____ (____) _____

Name of Employee (if different) _____ Relationship to Patient _____

Street Address _____ City, State, Zip, Phone _____ (____) _____

AUTHORIZES:

Patient's Health Care Provider _____

Street Address _____

City, State, Zip Code _____

DISCLOSURE OF PROTECTED HEALTH INFORMATION TO:

Name, Title, University of Wisconsin- _____

Street Address _____

City, State, Zip Code _____

INFORMATION TO BE USED &/or DISCLOSED:
The following is a specific description of the health information I authorize to be used and/or disclosed:

only information requested in the attached Physician Certification for Family or Medical Leave

In compliance with WI Statutes, which require special permission to release otherwise privileged information please release records pertaining to:
[Check all that apply]

☐ Mental Health ☐ Developmental Disabilities ☐ Alcohol &/or Drug Abuse ☐ HIV test results

☐ Other (Specify):_____

For the Following Date(s): From_____ To_____.

DISCLOSURE IS NEEDED TO DOCUMENT: (Check applicable categories)

☐ Employee's need for medical leave due to his/her own serious health condition

☐ Employee's need for family leave to care for the patient (parent, spouse, or child with a serious health condition).

☐ Other (Specify):_____.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:
Right to Receive Copy of This Authorization - I understand that if I sign this authorization, I will be provided with a copy of this authorization. **Right to Refuse to Sign This Authorization -** I understand that I am under no obligation to sign this form. However, the employee may be denied leave under the federal or state Family and Medical Leave Act if adequate documentation of the patient's serious health condition is not provided.
Right to Withdraw This Authorization - I understand that I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to my health care provider. I am aware that my withdrawal will not be effective until received by my health care provider and will not be effective regarding the uses and/or disclosures of my health information that my health care provider has made prior to receipt of my withdrawal statement. **Right to Inspect or Copy the Health Information to Be Used or Disclosed -** I understand that I have the right to inspect or copy (may be provided at a reasonable fee) the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect or obtain copies of the health information submitted to document the employee's eligibility for leave under the federal or state Family and Medical Leave Act by contacting the employee's University of Wisconsin Staff Benefits Office..
HIV TEST RESULTS: I understand my HIV test results may be released without authorization to persons/organizations that have access under s. 252.15(5)(a) of the Wisconsin statutes.

HIPAA COLLABORATIVE OF WISCONSIN

REDISCLOSURE NOTICE: I understand that information used or disclosed based on this authorization may be subject to re-disclosure and no longer protected by Federal privacy standards.

EXPIRATION DATE: This authorization is good until (indicate date or event) _____. By signing this authorization, I am confirming that it accurately reflects my wishes.

SIGNATURE PATIENT/LEGAL REP: _____ **DATE:** _____
(If signed by other than individual, state relationship with signature)

This authorization is prepared in conjunction with the HIPAA-COW Authorization/Informed Consent for Use and Disclosure of Health Care Information Grid that enumerates requirements of State and Federal privacy laws.

Prepared by: Susan Manning, JD, RHIA
Chrisann Lemery, RHIA

Date: 02/20/03
Revised: UW Office of Staff Benefits 5/19/03

AUTHORIZATION FOR FINAL DISPOSITION INSTRUCTIONS

Purpose of the Authorization for Final Disposition:

When properly completed and signed in the presence of two competent adult witnesses or a notary public, this voluntary document allows a competent adult (the declarant) to designate another competent adult (the representative or an alternative representative) to make funeral arrangements on behalf of the declarant.

This document allows the declarant to give his or her chosen representative information about the declarant's preferences for final disposition and funeral service.

Please read and understand the following information and the form before completing the form.

Definitions from Wisconsin State Statutes Chapter 154, Section 154.30 (8) (f):

- "Authorization for final disposition" means a document that satisfies the conditions under sub. (8) (d) or (dm), and that is voluntarily executed by a declarant under sub. (8), but is not limited in form or substance to that provided in sub. (8).
- "Cemetery authority" has the meaning given in s. 157.061 (2).
- "Credential" has the meaning given in s. 440.01 (2) (a).
- "Crematory authority" has the meaning given in s. 440.70 (9).
- "Declarant" means an individual who executes an authorization for final disposition.
- "Estranged" means being physically and emotionally alienated for a period of time, at the time of the decedent's death, and clearly demonstrating an absence of due affection, trust, and regard.
- "Final disposition" means disposition of a decedent's remains, including any of the following:
    1. Arrangements for a viewing.
    2. A funeral ceremony, memorial service, graveside service, or other last rite.
    3. A burial, cremation and burial, or other disposition, or donation of the decedent's body.

- "Funeral director" has the meaning given in s. 445.01 (5).
- "Health care provider" means any individual who has a credential to provide health care.
- "Representative" means an individual specifically designated in an authorization for final disposition or, if that individual is unable or unwilling to carry out the declarant's decisions and preferences, a successor representative designated in the authorization for final disposition to do so.

    154.30 (8) (e) If any of the following has a direct professional relationship with or provides professional services directly to the declarant and is not related to the declarant by blood, marriage, or adoption, that person may not serve as a representative under the requirements of this subsection:

    1. A funeral director.
    2. A crematory authority.
    3. A cemetery authority.
    4. An employee of a funeral director, crematory authority, or cemetery authority.
    5. A health care provider.
    6. A social worker.

Important Information

Declarant:

1. Properly completing this document (with all required signatures) automatically revokes any prior authorization for final disposition that the declarant may have signed.
2. The declarant may revoke this authorization for final disposition at any time by executing a new authorization form; by signing and dating a statement declaring this document to be cancelled, revoked or void; by destroying or defacing this form; or by writing on this form, "I hereby revoke this declaration of final disposition," and signing and dating that statement.
3. If the declarant is physically unable to sign an authorization for final disposition, the authorization shall be signed in the declarant's name by an individual at the declarant's express direction and in his or her presence; such a proxy signing shall take place or be acknowledged by the declarant in the presence of 2 witnesses or a notary public.

Representative:

1. An individual who is authorized by this document to control the declarant's final disposition may accept the control, may decline to exercise the control, or may, after accepting the control, resign it.
2. If there is a dispute about the declarant's disposition, the probate court for the county in which the decedent last resided has exclusive jurisdiction over the case.
3. The representative signing this document is expected to carry out the directions, instructions, and suggestions for disposition specified in this document unless the directions, instructions, and suggestions exceed available resources from the decedent's estate or are unlawful or unless there is no realistic possibility of compliance.

AUTHORIZATION FOR FINAL DISPOSITION

I, _____
(Print Name)

Residing at _____,
(Print Mailing Address)

being of sound mind, willfully and voluntarily make known by this document my desire that, upon my death, the final disposition of my remains be under the control of my representative under the requirements of section 154.30, Wisconsin statutes, and, with respect to that final disposition only, I hereby appoint the representative and any successor representative named in this document. All decisions made by my representative or any successor representative with respect to the final disposition of my remains are binding.

Name of Representative _____

Address _____

Telephone number (include area code) _____

If my representative dies, becomes incapacitated, resigns, refuses to act, ceases to be qualified, or cannot be located within the time necessary to control the final disposition of my remains, I hereby appoint the following individuals, each to act alone and successively, in the order specified, to serve as my successor representative:

1. Name of first successor representative _____

Address _____

Telephone number (include area code) _____

2. Name of second successor representative _____

Address _____

Telephone number (include area code) _____

SUGGESTED SPECIAL DIRECTIONS

1. Arrangements for a viewing.
2. Funeral ceremony, memorial service, graveside service, or other last rite.
3. Burial, cremation and burial or other disposition, or donation of the declarant's body after death.

SUGGESTED INSTRUCTIONS CONCERNING RELIGIOUS OBSERVANCES

SUGGESTED SOURCE OF FUNDS FOR IMPLEMENTING FINAL DISPOSITION DIRECTIONS AND INSTRUCTIONS

This authorization becomes effective upon my death. I hereby revoke any prior authorization for final disposition that I may have signed before the date that this document is signed.

I hereby agree that any funeral director, crematory authority, or cemetery authority that receives a copy of this document may act under it. Any modification or revocation of this document is not effective as to a funeral director, crematory authority, or cemetery authority until the funeral director, crematory authority, or cemetery authority receives actual notice of the modification or revocation. No funeral director, crematory authority, or cemetery authority may be liable because of reliance on a copy of this document.

The representative and any successor representative, by accepting appointment under this document, assume the powers and duties specified for a representative under section 154.30, Wisconsin statutes.

Signed this _____ day of _____
(Day) (Month and Year)

Signature of declarant _____

I hereby accept appointment as representative for the control of final disposition of the declarant's remains.

Signed this _____ day of _____
(Day) (Month and Year)

Signature of representative _____

I hereby accept appointment as successor representative for the control of final disposition of the declarant's remains.

Signed this _____ day of _____
(Day) (Month and Year)

Signature of first successor representative _____

Signed this _____ day of _____
(Day) (Month and Year)

Signature of second successor representative _____

I attest that the declarant signed or acknowledged this authorization for final disposition in my presence and that the declarant appears to be of sound mind and not subject to duress, fraud, or undue influence. I further attest that I am not the representative or the successor representative appointed under this document that I am aged at least 18, and that I am not related to the declarant by blood, marriage, or adoption.

1st Witness (print name) _____

Signature _____

Address _____

Date (Month, Day, Year) _____

2nd Witness (print name) _____

Signature _____

Address _____

Date (Month, Day, Year) _____

In lieu of two witnesses signing this form, the declarant may sign it in the presence of a notary public.

State of Wisconsin, County of _____

On (date) _____, before me personally appeared

(name of declarant) _____ known to me or satisfactorily proven to be the individual whose name is specified in this document as the declarant and who has acknowledged that he or she executed the document for the purposes expressed in it. I attest that the declarant appears to be of sound mind and not subject to duress, fraud, or undue influence.

Notary Public Name: _____ Signature _____

My commission expires (date) _____ (Seal)