

# What You Should Know About Healthcare Power of Attorney, Living Will and Organ Donation

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## What Are My Rights?

### ***Who decides about my medical care or treatment?***

If you are eighteen (18) or older and mentally competent, you have the right to make decisions about your medical treatment. You should always talk to your doctor or other health care provider about any treatment or procedure so that you understand what will be done and why. You have the right to say “yes” or “no” to treatments recommended by your doctor. If you want to have more control over decisions about your health care, even if you become unable to make or to express them yourself, you might consider an “advance directive.”

### ***What is an “advance directive”?***

An advance directive is a set of directions you give about the health care you want for yourself if you lose the ability to make or express these decisions. Two (2) common types of advanced directives used in North Carolina are the:

- Health Care Power of Attorney; and
- Advance Directive for a Natural Death or “living will”.

You might also consider making a declaration of anatomical gift.

### ***Do I have to have an advance directive?***

No. Making a health care power of attorney or a living will is your choice. You will be given the highest quality of care whether or not you have an advance directive. If you become unable to make your own decisions, and you do not have an advance directive, your doctor or health care provider will consult with someone close to you about your care.

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## Health Care Power Of Attorney

### ***What is a health care power of attorney?***

In North Carolina, you can choose a person to make medical care decisions for you in the event you are unable to

make or communicate those decisions yourself. This person is called your “health care agent.” In the legal document, you designate who you want your agent to be. You can also indicate what medical treatments you would want and what you would not want, name a particular physician to determine when you lack the capacity to make or communicate health care decisions, and grant your health care agent the authority to donate organs and parts or your body for anatomical gifts.

### ***How should I choose a health care agent?***

You should choose an adult you trust that can make difficult decisions regarding your medical treatment if need be and speak for you. Discuss your values and preferences with this person before you put their name in writing.

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## Living Will

### ***What is a living will?***

In North Carolina, a living will is a document that allows you to authorize or direct the withholding or withdrawal of life-prolonging measures in the following circumstances: (1) you are determined to have an incurable or irreversible condition that (your attending physician believes) will result in your death within a relatively short period of time; (2) you are unconscious and (your attending physician believes) you will never regain consciousness; and (3) you suffer from advanced dementia or another condition which results in the substantial loss of your cognitive ability and (your attending physician believes) this loss is not reversible. In a living will, you can tell your doctor that you want to die a natural death. For example, you can direct your doctor not to begin or to stop giving you artificial nutrition and/or hydration (through a tube).



**APPALACHIAN REGIONAL  
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## **Declaration Of Anatomical Gift: Organ Donation**

If you wish to be an organ donor, you should indicate this on your driver's license AND sign and carry a donor card. To ensure families are provided an opportunity to consider organ/tissue/eye donation and to comply with federal regulation, a designated hospital staff member will notify Carolina Donor Services of every death or imminent death in a timely manner. If an appropriate referral is made, Carolina Donor Service will contact family members to discuss the possibility of organ/tissue/eye donations.

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## **Other Questions**

### ***How do I make an advance directive?***

You must follow several rules when you make a formal health care power of attorney or living will. These rules are to protect you and ensure that your wishes are clear to the doctor or other providers who may be asked to carry them out. These documents must be in writing and signed by you while you are still able to understand your treatment choices and to make and communicate your health care decisions. They must also be signed by two (2) qualified witnesses and notarized.

### ***Are there forms I can use to make an advance directive?***

Yes. Health care power of attorney and living will forms are located in the back of this brochure. These forms meet all applicable rules and are the best way to make sure that your wishes are known.

### ***When does an advance directive go into effect?***

The powers granted to your health care power of attorney go into effect when your physician (the one designated or, if unavailable or none, your attending physician) states in writing that you are unable to make or communicate your own health care decisions. A living will goes into effect when, as specified: (1) you have an incurable or irreversible condition that (your attending physician believes) will result in death within a relatively short period of time; (2) you are unconscious and (your attending physician believes) you will never regain consciousness; or (3) you suffer from advanced dementia or another condition which results in the substantial loss of your cognitive ability and (your attending physician believes) this loss is not reversible.

### ***Can I change my mind?***

Yes. You can cancel your health care power of attorney so long as you are able to make and communicate health care decisions. You can execute or acknowledge an instrument of revocation or a subsequent health care power of attorney or communicate your intent to revoke. This revocation is effective only when you communicate it to each health care agent named in the revoked document and your attending physician. You can cancel your living will at any time, in writing or in any clear and consistent manner, regardless of your physical or mental condition. Informing your physician is sufficient. You should also destroy the original and any copies of the advanced directive that has been canceled.

### ***Whom should I talk to about an advance directive?***

You should talk to those closest to you about an advance directive. Discuss your preferences and values, the treatment you wish to receive generally, and the treatment you wish to receive at the end of your life. Your health care provider can answer medical questions and discuss end-of-life options. You may also wish to consult with an attorney if you have more specific questions about the law. Some people also find it helpful to discuss an advance directive with their pastor, priest, rabbi, or other trusted advisors.

### ***Where should I keep my advance directive?***

Keep a copy in a safe place where your family members can access it if need be. Give copies to your family, hospital, and your health care agent. You can also register any advance directive on the internet at [www.sosnc.gov/ahcdr](http://www.sosnc.gov/ahcdr).

### ***What if I have an advance directive from another state?***

An advance directive from another state may not meet all of North Carolina's rules. To be certain, you should consider making an advance directive in North Carolina or having a lawyer review the advance directive from another state.

### ***Where can I get more information?***

You get more information by contacting:

**Care Management Department**  
**Charles A. Cannon, Jr. Memorial Hospital**  
**(828) 737-7596**  
**Watauga Medical Center**  
**(828) 262-4121**

# HEALTH CARE POWER OF ATTORNEY

**NOTE: YOU SHOULD USE THIS DOCUMENT TO NAME A PERSON AS YOUR HEALTH CARE AGENT IF YOU ARE COMFORTABLE GIVING THAT PERSON BROAD AND SWEEPING POWERS TO MAKE HEALTH CARE DECISIONS FOR YOU. THERE IS NO LEGAL REQUIREMENT THAT ANYONE EXECUTE A HEALTH CARE POWER OF ATTORNEY.**

***EXPLANATION:** You have the right to name someone to make health care decisions for you when you cannot make or communicate those decisions. This form may be used to create a health care power of attorney, and meets the requirements of North Carolina law. However, you are not required to use this form, and North Carolina law allows the use of other forms that meet certain requirements. If you prepare your own health care power of attorney, you should be very careful to make sure it is consistent with North Carolina law.*

*This document gives the person you designate as your health care agent **broad powers** to make health care decisions for you when you cannot make the decision yourself or cannot communicate your decision to other people. You should discuss your wishes concerning life prolonging measures, mental health treatment, and other health care decisions with your health care agent. Except to the extent that you express specific limitations or restrictions in this form, your health care agent may make any health care decision you could make yourself.*

*This form does not impose a duty on your health care agent to exercise granted powers, but when a power is exercised, your health care agent will be obligated to use due care to act in your best interests and in accordance with this document.*

*This Health Care Power of Attorney form is intended to be valid in any jurisdiction in which it is presented, but places outside North Carolina may impose requirements that this form does not meet.*

*[If you want to use this form, you must complete it, sign it, and have your signature witnessed by two qualified witnesses and proved by a notary public. Follow the instructions about which choices you can initial very carefully. **Do not sign this form until** two witnesses and a notary public are present to watch you sign it. You then should give a copy to your health care agent and to any alternates you name. You should consider filing it with the Advance Health Care Directive Registry maintained by the North Carolina Secretary of State: <https://www.sosnc.gov/ahcdr/>]*

## 1. Designation of Health Care Agent.

I, \_\_\_\_\_, being of sound mind, hereby appoint the following person(s) to serve as my health care agent(s) to act for me and in my name (in any way I could act in person) to make health care decisions for me as authorized in this document. My designated health care agent(s) **shall serve alone, in the order named.**

Name: \_\_\_\_\_  
Home Address: \_\_\_\_\_  
Home Telephone Number: \_\_\_\_\_  
Work Telephone Number: \_\_\_\_\_  
Cell Telephone Number: \_\_\_\_\_

Name: \_\_\_\_\_  
Home Address: \_\_\_\_\_  
Home Telephone Number: \_\_\_\_\_  
Work Telephone Number: \_\_\_\_\_  
Cell Telephone Number: \_\_\_\_\_

Name: \_\_\_\_\_  
Home Address: \_\_\_\_\_  
Home Telephone Number: \_\_\_\_\_  
Work Telephone Number: \_\_\_\_\_  
Cell Telephone Number: \_\_\_\_\_

Any successor health care agent designated shall be vested with the same power and duties as if originally named as my health care agent, and shall serve any time his or her predecessor is not reasonably available or is unwilling or unable to serve in that capacity.

## **2. Effectiveness of Appointment.**

My designation of a health care agent expires only when I revoke it. Absent revocation, the authority granted in this document shall become effective when and if one of the physician(s) listed below determines that I lack capacity to make or communicate decisions relating to my health care, and will continue in effect during that incapacity, or until my death, except if I authorize my health care agent to exercise my rights with respect to anatomical gifts, autopsy, or disposition of my remains, this authority will continue after my death to the extent necessary to exercise that authority.

1. \_\_\_\_\_ (*Physician*)
2. \_\_\_\_\_ (*Physician*)

If I have not designated a physician, or no physician(s) named above is reasonably available, the determination that I lack capacity to make or communicate decisions relating to my health care shall be made by my then attending physician.

## **3. Revocation.**

Any time while I am competent, I may revoke this power of attorney in a writing I sign or by communicating my intent to revoke, in any clear and consistent manner, to my health care agent or my health care provider.

## **4. General Statement of Authority Granted.**

Subject to any restrictions set forth in Section 5 below, I grant to my health care agent full power and authority to make and carry out all health care decisions for me. These decisions include, but are not limited to:

- A. Requesting, reviewing, and receiving any information, verbal or written, regarding my physical or mental health, including, but not limited to, medical and hospital records, and to consent to the disclosure of this information.
- B. Employing or discharging my health care providers.
- C. Consenting to and authorizing my admission to and discharge from a hospital, nursing or convalescent home, hospice, long term care facility, or other health care facility.
- D. Consenting to and authorizing my admission to and retention in a facility for the care or treatment of mental illness.
- E. Consenting to and authorizing the administration of medications for mental health treatment and electroconvulsive treatment (ECT) commonly referred to as “shock treatment.”

- F. Giving consent for, withdrawing consent for, or withholding consent for, X-ray, anesthesia, medication, surgery, and all other diagnostic and treatment procedures ordered by or under the authorization of a licensed physician, dentist, podiatrist, or other health care provider. This authorization specifically includes the power to consent to measures for relief of pain.
- G. Authorizing the withholding or withdrawal of life prolonging measures.
- H. Providing my medical information at the request of any individual acting as my attorney in fact under a durable power of attorney or as a Trustee or successor Trustee under any Trust Agreement of which I am a Grantor or Trustee, or at the request of any other individual whom my health care agent believes should have such information. I desire that such information be provided whenever it would expedite the prompt and proper handling of my affairs or the affairs of any person or entity for which I have some responsibility. In addition, I authorize my health care agent to take any and all legal steps necessary to ensure compliance with my instructions providing access to my protected health information. Such steps shall include resorting to any and all legal procedures in and out of courts as may be necessary to enforce my rights under the law and shall include attempting to recover attorneys' fees against anyone who does not comply with this health care power of attorney.
- I. To the extent I have not already made valid and enforceable arrangements during my lifetime that have not been revoked, exercising any right I may have to authorize an autopsy or direct the disposition of my remains.
- J. Taking any lawful actions that may be necessary to carry out these decisions, including, but not limited to: (i) signing, executing, delivering, and acknowledging any agreement, release, authorization, or other document that may be necessary, desirable, convenient, or proper in order to exercise and carry out any of these powers; (ii) granting releases of liability to medical providers or others; and (iii) incurring reasonable costs on my behalf related to exercising these powers, provided that this health care power of attorney shall not give my health care agent general authority over my property or financial affairs.

**5. Special Provisions and Limitations.**

(Notice: The authority granted in this document is intended to be as broad as possible so that your health care agent will have authority to make any decisions you could make to obtain or terminate any type of health care treatment or service. If you wish to limit the scope of your health care agent's powers, you may do so in this section. If none of the following are initialed, there will be no special limitations on your agent's authority.)

A. Limitations about Artificial Nutrition or Hydration: In exercising the authority to make health care decisions on my behalf, my health care agent:

\_\_\_\_\_ shall NOT have the authority to withhold artificial nutrition (such as through tubes) OR  
 Initial may exercise that authority only in accordance with the following special provisions:  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_ shall NOT have the authority to withhold artificial hydration (such as through tubes) OR  
 Initial may exercise that authority only in accordance with the following special provisions:  
 \_\_\_\_\_  
 \_\_\_\_\_

**NOTE: If you initial either block but do not insert any special provisions, your health care agent shall have NO AUTHORITY to withhold artificial nutrition or hydration.**

B. Limitations Concerning Health Care Decisions.

\_\_\_\_\_  
Initial

In exercising the authority to make health care decisions on my behalf, the authority of my health care agent is subject to the following special provisions: (Here you may include any specific provisions you deem appropriate such as: your own definition of when life-prolonging measures should be withheld or discontinued, or instructions to refuse any specific types of treatment that are inconsistent with your religious beliefs, or are unacceptable to you for any other reason.)

\_\_\_\_\_  
\_\_\_\_\_

**NOTE: DO NOT initial unless you insert a limitation.**

C. Limitations Concerning Mental Health Decisions.

\_\_\_\_\_  
Initial

In exercising the authority to make mental health decisions on my behalf, the authority of my health care agent is subject to the following special provisions: (Here you may include any specific provisions you deem appropriate such as: limiting the grant of authority to make only mental health treatment decisions, your own instructions regarding the administration or withholding of psychotropic medications and electroconvulsive treatment (ECT), instructions regarding your admission to and retention in a health care facility for mental health treatment, or instructions to refuse any specific types of treatment that are unacceptable to you.)

\_\_\_\_\_  
\_\_\_\_\_

**NOTE: DO NOT initial unless you insert a limitation.**

D. Advance Instruction for Mental Health Treatment.

\_\_\_\_\_  
Initial

(Notice: health care power of attorney may incorporate or be combined with an advance instruction for mental health treatment, executed in accordance with Part 2 of Article 3 of Chapter 122C of the General Statutes, which you may use to state your instructions regarding mental health treatment in the event you lack capacity to make or communicate mental health treatment decisions. Because your health care agent's decisions must be consistent with any statements you have expressed in an advance instruction, you should indicate here you have executed an advance instruction for mental health treatment):

\_\_\_\_\_  
\_\_\_\_\_

**NOTE: DO NOT initial unless you insert a limitation.**

E. Autopsy and Disposition of Remains.

\_\_\_\_\_ Initial In exercising the authority to make decisions regarding autopsy and disposition of remains on my behalf, the authority of my health care agent is subject to the following special provisions and limitations. (Here you may include any specific limitations you deem appropriate such as: limiting the grant of authority and the scope of authority, or instructions regarding burial or cremation):

\_\_\_\_\_  
\_\_\_\_\_

**NOTE: DO NOT initial unless you insert a limitation.**

**6. Organ Donation.**

To the extent I have not already made valid and enforceable arrangements during my lifetime that have not been revoked, my health care agent may exercise any right I may have to:

\_\_\_\_\_ Initial donate any needed organs or parts; or

\_\_\_\_\_ Initial donate only the following organs or parts:

\_\_\_\_\_  
\_\_\_\_\_

**NOTE: DO NOT INITIAL BOTH BLOCKS ABOVE.**

\_\_\_\_\_ Initial donate my body for anatomical study if needed.

\_\_\_\_\_ Initial In exercising the authority to make donations, my health care agent is subject to the following special provisions and limitations: (Here you may include any specific limitations you deem appropriate such as: limiting the grant of authority and the scope of authority, or instructions regarding gifts of the body or body parts.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**NOTE: DO NOT initial unless you insert a limitation.**

**NOTE: NO AUTHORITY FOR ORGAN DONATION IS GRANTED IN THIS INSTRUMENT WITHOUT YOUR INITIALS.**

**7. Guardianship Provision.**

If it becomes necessary for a court to appoint a guardian of my person, I nominate the persons designated in Section 1, in the order named, to be the guardian of my person, to serve without bond or security. The guardian shall act consistently with G.S. 35A 1201(a)(5).

## **8. Reliance of Third Parties on Health Care Agent.**

- A. No person who relies in good faith upon the authority of or any representations by my health care agent shall be liable to me, my estate, my heirs, successors, assigns, or personal representatives, for actions or omissions in reliance on that authority or those representations.
- B. The powers conferred on my health care agent by this document may be exercised by my health care agent alone, and my health care agent's signature or action taken under the authority granted in this document may be accepted by persons as fully authorized by me and with the same force and effect as if I were personally present, competent, and acting on my own behalf. All acts performed in good faith by my health care agent pursuant to this power of attorney are done with my consent and shall have the same validity and effect as if I were present and exercised the powers myself, and shall inure to the benefit of and bind me, my estate, my heirs, successors, assigns, and personal representatives. The authority of my health care agent pursuant to this power of attorney shall be superior to and binding upon my family, relatives, friends, and others.

## **9. Miscellaneous Provisions.**

- A. **Revocation of Prior Powers of Attorney.** I revoke any prior health care power of attorney. The preceding sentence is not intended to revoke any general powers of attorney, some of the provisions of which may relate to health care; however, this power of attorney shall take precedence over any health care provisions in any valid general power of attorney I have not revoked.
- B. **Jurisdiction, Severability, and Durability.** This Health Care Power of Attorney is intended to be valid in any jurisdiction in which it is presented. The powers delegated under this power of attorney are severable, so that the invalidity of one or more powers shall not affect any others. This power of attorney shall not be affected or revoked by my incapacity or mental incompetence.
- C. **Health Care Agent Not Liable.** My health care agent and my health care agent's estate, heirs, successors, and assigns are hereby released and forever discharged by me, my estate, my heirs, successors, assigns, and personal representatives from all liability and from all claims or demands of all kinds arising out of my health care agent's acts or omissions, except for my health care agent's willful misconduct or gross negligence.
- D. **No Civil or Criminal Liability.** No act or omission of my health care agent, or of any other person, entity, institution, or facility acting in good faith in reliance on the authority of my health care agent pursuant to this Health Care Power of Attorney shall be considered suicide, nor the cause of my death for any civil or criminal purposes, nor shall it be considered unprofessional conduct or as lack of professional competence. Any person, entity, institution, or facility against whom criminal or civil liability is asserted because of conduct authorized by this Health Care Power of Attorney may interpose this document as a defense.
- E. **Reimbursement.** My health care agent shall be entitled to reimbursement for all reasonable expenses incurred as a result of carrying out any provision of this directive.

## **10. Special HIPAA Provisions.**

- A. I intend for my health care agent to be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (aka HIPAA), 42 USC 1320d and 45 CFR 160-164.

B. I authorize any physician, health care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy or other covered health care provider, any insurance company and the Medical Information Bureau Inc. or other health care clearinghouse that has provided treatment or services to me or that has paid for or is seeking payment from me for such services to give, disclose and release to my health care agent, without restriction, all of my individually identifiable health information and medical records regarding any past, present or future medical or mental health condition, to include all information relating to the diagnoses and treatment of HIV/AIDS, sexually transmitted diseases, mental illness and drug or alcohol abuse. The authority given my health care agent shall supersede any prior agreement that I may have made with my health care providers to restrict access to or disclosure of my individually identifiable health information. The authority given my health care agent has no expiration date and shall expire only if I revoke the authority in writing and deliver it to my health care provider.

By signing here, I indicate that I am mentally alert and competent, fully informed as to the contents of this document, and understand the full import of this grant of powers to my health care agent.

This the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_ (SEAL)

I hereby state that the principal, \_\_\_\_\_, being of sound mind, signed (or directed another to sign on the principal's behalf) the foregoing health care power of attorney in my presence, and that I am not related to the principal by blood or marriage, and I would not be entitled to any portion of the estate of the principal under any existing will or codicil of the principal or as an heir under the Intestate Succession Act, if the principal died on this date without a will. I also state that I am not the principal's attending physician, nor a licensed health care provider or mental health treatment provider who is (1) an employee of the principal's attending physician or mental health treatment provider, (2) an employee of the health facility in which the principal is a patient, nor (3) an employee of a nursing home or any adult care home where the principal resides. I further state that I do not have any claim against the principal or the estate of the principal.

Date: \_\_\_\_\_ Witness: \_\_\_\_\_

Date: \_\_\_\_\_ Witness: \_\_\_\_\_

STATE OF NORTH CAROLINA  
COUNTY OF \_\_\_\_\_

Sworn to (or affirmed) and subscribed before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_, by \_\_\_\_\_, and \_\_\_\_\_ and \_\_\_\_\_ as witnesses.

\_\_\_\_\_  
Notary Public

My commission expires: \_\_\_\_\_