

ADVANCE DIRECTIVE FOR HEALTH CARE
-- NEW MEXICO --

(1) DESIGNATION OF AGENT:

I, _____, appoint _____ as my agent to make health care decisions for me. If my agent is deceased, incapacitated or resigns, then I appoint _____ as my agent to make health care decisions for me.

(2) AGENT'S AUTHORITY:

My agent may make all health care decisions for me, including obtaining and reviewing medical records, reports and information about me, except to the extent I limit my agent's authority as follows:

If you do not limit your agent's authority, your agent will have the right to:

- (a) *consent to or refuse consent to any medical care, treatment, service or procedure, such as: diagnostic tests, home health care, surgery, orders not to resuscitate, medication, nursing care, lifesaving & life prolonging medical treatment provision, withholding or withdrawal of artificial nutrition and hydration, hospitalization, and all other forms of health care*

and

- (b) *select or change health care providers and institutions.*

I authorize any physician, health care professional, dentist, hospital, clinic, laboratory, pharmacy, or other health care provider, any insurance company or health care clearinghouse that has provided treatment or services to me to release to my agent all of my health information and medical records. I appoint my agent as my personal representative for all purposes of the Health Insurance Portability and Accountability Act of 1996 (as amended) during any time that my agent is exercising authority under this document. I specifically authorize my agent to receive all information regarding my physical or mental health, and to execute, on my behalf, any documents required to obtain information.

(3) AGENT'S RESPONSIBILITY: My agent shall make health care decisions for me based on this durable power of attorney for health care, any specific health care instructions I give and my other wishes to the extent known to my agent. If my wishes are unknown and cannot be determined, my agent shall make health care decisions for me based on my best interest. In determining my best interest, my agent shall consider my personal values to the extent known.

(4) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when my primary physician and one other qualified health care professional determine that I lack the capacity to make and communicate my own health care decisions.

(5) **DURABILITY:** This durable power of attorney for health care decisions shall remain in effect despite my later incapacity. This power of attorney remains in effect from the date it was signed unless I revoke it or die.

(6) **END-OF-LIFE DECISIONS**

- (a) If I have an incurable and irreversible condition that will result in my death within a relatively short time; OR
- (b) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness; OR
- (c) the likely risks and burdens of treatment would outweigh the expected benefits;

THEN I direct that my health care providers and others involved in my care provide, withhold or withdraw treatment in accordance with the choice I initial below on one of the following three lines:

- initial* _____ **I Choose to Prolong Life:** I want my life to be prolonged as long as possible within the limits of generally accepted health care standards. OR
- only* _____
- one* * _____ **I Choose NOT to Prolong Life:** I do not want my life to be prolonged. I understand that "NOT prolonging my life" means that I do not want any life support measures. OR
- space* _____ **I Choose to Let My Agent Decide:** My agent under my power of attorney for health care may make end-of-life decisions for me.

(7) **ARTIFICIAL NUTRITION AND HYDRATION:**

If, in the above paragraph, I have chosen "NOT To Prolong Life", I also specify:

- initial your* _____ **I DO Want Artificial Nutrition (food)**
- choice in* _____ OR
- these spaces* * _____ **I DO NOT WANT Artificial Nutrition (food)**
- _____ OR
- _____ **I DO Want Artificial Hydration (water)**
- _____ OR
- * _____ **I DO NOT WANT Artificial Hydration (water)**

No matter which choices I have initialed in this section, I do want comfort care.

(8) **ORGAN DONATION AND CREMATION INSTRUCTIONS:**

I authorize my agent to consent to: (check your choices)

Organ donation _____ Yes _____ No
Cremation _____ Yes _____ No

(9) RELIEF FROM PAIN OR DISCOMFORT: I direct that treatment for easing my pain or discomfort be provided at all times, even if it hastens my death, unless I state otherwise in the following space:

(10) OTHER HEALTH CARE INSTRUCTIONS OR WISHES: If you wish to write specific instructions about any aspect of your health care and medical treatment, including your end-of-life decisions, you may do so here. I direct that:

(11) NOMINATION OF GUARDIAN: I intend by this power of attorney for health care decisions to avoid a court-supervised guardianship. If I need a guardian, I want my agent appointed in this form to be my guardian. If that agent cannot or will not act as my guardian, I want my alternative agents, in the order they are appointed in this form, to be my guardian.

(12) COPIES OF THIS FORM: Photocopies of this document shall have the same force and effect as the original.

(13) REVOCATION: I may revoke my Health Care Instructions (Sections 6-9 of this form) in any way that shows my intent to do so. I may revoke the appointment of an agent under my durable power of attorney for health care (Section 1 of this form) by a signed writing or by telling my doctor. If I revoke any or all of this form, I should promptly notify my doctor, my agent, any health care institution where I am receiving care, and any others who have copies of it.

SIGN AND DATE BELOW:

(date)

WITNESS

WITNESS