

THE LAW OFFICE OF ROBERT H. PAINE, PLLC

**GUIDE TO ADVANCE HEALTH CARE
DIRECTIVES IN MISSISSIPPI**

1006 Van Buren Avenue • Suite 201
Oxford, MS 38655
Phone 662.236.9901 • Fax 662.236.9902

405 Tombigbee Street
Jackson, MS 39201
Phone 601.949.3300 • Fax 601.354.5548

robert@painelawoffice.com
www.painelawoffice.com

INTRODUCTION

An advance health care directive is a written instruction recognized under State law which relates to the provision of health care when an individual is incapacitated. Advance health care directives allow an individual to make present decisions regarding future health care issues.

In 1998 the Mississippi Legislature enacted the Uniform Health-Care Decisions Act ("the Act"), effective July 1, 1998. The Act provides that an advance health care directive is the means by which an individual can make his or her wishes known in the event he or she becomes incapacitated. The Act repealed previous statutes that authorized the use of living wills and durable powers of attorney for health care.

The following summary provides an explanation of the use of advance health care directives in Mississippi and sets out a description of Mississippi law pertaining to advance health care directives.

ADVANCE HEALTH CARE DIRECTIVE

Any competent adult 18 years or older has the right to make health care decisions. In Mississippi the means to make future health care decisions is by executing an advance directive. Mississippi recognizes two types of advance directives: a Power of Attorney for Health Care and an Individual Instruction.

A Power of Attorney for Health Care is a written document by which an individual (the "principal") designates an agent to make health care decisions in the event the individual is rendered incapacitated. Individual Instructions may be included in any Power of Attorney for Health Care. A copy of a Power of Attorney for Health Care should be given to the agent named in the document and a copy should be given to an individual's health care provider. A Power of Attorney for Health Care is valid until an individual revokes it by oral or written instructions. It must be dated, signed by the principal, and witnessed by either the signatures of two individuals or by a notary public.

An Individual Instruction is an oral or written directive concerning future health care issues. Mississippi law does not require individual instructions to be in any particular format. An acceptable format for an individual instruction can be found in Part 2 of the Form included in this Guide. An Individual Instruction should be delivered to an individual's health care provider and any individual designated to make future health care decisions, if any. An Individual Instruction is valid until an individual revokes it by oral or written instructions.

It is advisable for an individual to complete both a power of attorney for health care and an individual instruction.

If an individual does not wish to make an advance directive, he or she may designate an individual to serve as a surrogate who will make health care decisions in the event of incapacity. If an individual does not have an advance directive and has not named a surrogate, then a family member may make health care decisions. If an individual does not have an advance directive, has not named a surrogate and has no family members, then a court might have to make decisions regarding an individual's health care.

Many individuals question the need to make an advance health care directive. Usually the agent named in an advance directive is a family member. If an individual does not have a directive, then family members will make health care decisions in the event of incapacity. So, many individuals think that an advance directive is not necessary because family members will make the decisions either way. However, family members might disagree amongst themselves or with the attending physician as to health care decisions and create conflict and deadlock. Therefore, an advance directive can help to resolve who will have the ultimate authority to make health care decisions and reduce the possibility of conflict.

Any advance health care directive must meet the requirements of Mississippi law. Mississippi law requires that an advance directive, to be effective, must be executed while a resident of the State of Mississippi. Therefore, if an individual executed a directive while they resided in another state, it is wise to execute new documents which will satisfy the requirements of the Mississippi statute.

**MISSISSIPPI ADVANCE
HEALTH CARE DIRECTIVE OF**

**PART I
POWER OF ATTORNEY FOR HEALTH CARE**

(1) **DESIGNATION OF AGENT:** I designate the following individual as my agent to make health-care decisions for me:

(name of individual you choose as agent)

(address)

(city)

(state)

(zip code)

(home phone)

(work phone)

OPTIONAL: If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health-care decision for me, I designate as my first alternate agent:

(name of individual you choose as first alternate agent)

(address)

(city)

(state)

(zip code)

(home phone)

(work phone)

OPTIONAL: If I revoke the authority of my agent and first alternate agent or if neither is willing, able, or reasonably available to make a health-care decision for me, I designate as my second alternate agent:

(name of individual you choose as second alternate agent)

(address)

(city)

(state)

(zip code)

(home phone)

(work phone)

OPTIONAL: If I revoke the authority of my agent, first alternate agent, and second alternate agent, or if neither is willing, able, or reasonably available to make a health-care decision for me, I designate as my third alternate agent:

(name of individual you choose as third alternate agent)

(address)

(city)

(state)

(zip code)

(home phone)

(work phone)

(2) **AGENT'S AUTHORITY:** My agent is authorized to make all health-care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration, and all other forms of health-care to keep me alive, except as I state here:

(3) **WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE:** My agent's authority becomes effective when my primary physician determines that I am unable to make my own health-care decisions unless I mark the following box. If I mark this box [], my agent's authority to make health-care decisions for me takes effect immediately.

(4) **AGENT'S OBLIGATION:** My agent shall make health-care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health-care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

(5) NOMINATION OF GUARDIAN: If a guardian of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able, or reasonably available to act as guardian, I nominate the alternate agents whom I have named, in the order designated.

(6) HIPPA RELEASE AUTHORITY: My agent shall 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 or other medical records. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (HIPPA), 42 U.S.C. 1320 and 45 CFR 160 through 164. 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 me, or that has paid for or is seeking payment from me for such services, to give, disclose, and release to my agent, without restriction, all of my individually identifiable health information and medical records regarding any past, present or future medical or mental health condition, including all information relating to the diagnosis of HIV/AIDS, sexually transmitted diseases, mental illness, and drug or alcohol abuse. The authority given my agent shall supersede any other agreement that I may have with my health care providers to restrict access to or disclosure of my individually identifiable health information. The authority given my agent has no expiration date and shall expire only in the event that I revoke the authority in writing and deliver it to my health care provider.

PART 2
INSTRUCTIONS FOR HEALTH CARE

If you would like to give specific instructions for your health care providers to follow in the event of incapacity, fill out this part of the form. If you are satisfied to allow your agent to determine what is best for you in making end-of-life decisions, you need not fill out this part of the form.

(6) END-OF-LIFE DECISIONS: I direct that my health-care providers and others involved in my care provide, withhold or withdraw treatment in accordance with the choice I have marked below:

(a) Choice Not To Prolong Life: I do not want my life to be prolonged in the following circumstances:

(i) I have an incurable and irreversible condition that will result in my death within a relatively short time,

(ii) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness,

(iii) the likely risks and burdens of treatment would outweigh the expected benefits, or

(b) Choice To Prolong Life: I want my life to be prolonged as long as possible within the limits of generally accepted health-care standards.

(7) ARTIFICIAL NUTRITION AND HYDRATION: Artificial nutrition and hydration must be provided, withheld or withdrawn in accordance with the choice I have made in paragraph (6) unless I mark the following box. If I mark this box , artificial nutrition and hydration must be provided regardless of my condition and regardless of the choice I have made in paragraph (6).

(8) **RELIEF FROM PAIN:** Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death:

(9) **OTHER WISHES:** (If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:

**PART 3
PRIMARY PHYSICIAN**

OPTIONAL

(10) I designate the following physician as my primary physician:

(name of primary physician)

(address)

(city)

(state)

(zip code)

(phone)

OPTIONAL: If the physician I have designated above is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician:

(name of individual you choose as agent)

(address)

(city)

(state)

(zip code)

(phone)

(11) **EFFECT OF COPY:** A copy of this form has the same effect as the original.

(12) SIGNATURES:

Print Your Name

Sign Your Name

Date

Address

City

State

(13) WITNESSES: This power of attorney will not be valid for making health-care decisions unless it is either (a) signed by two (2) qualified adult witnesses who are personally known to you and who are present when you sign or acknowledge your signature; or (b) acknowledged before a notary public in the state.

ALTERNATIVE NO. 1

Witness #1

I declare under penalty of perjury pursuant to Section 97-9-61, Mississippi Code of 1972, that the principal is personally known to me, that the principal signed or acknowledged this power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud or undue influence, that I am not the person appointed as agent by this document, and that I am not a health-care provider, nor an employee of a health-care provider or facility. I am not related to the principal by blood, marriage or adoption, and to the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

Signature of Witness

Date

Address

City

State

Witness #2

I declare under penalty of perjury pursuant to Section 97-9-61, Mississippi Code of 1972, that the principal is personally known to me, that the principal signed or acknowledged this power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud or undue influence, that I am not the person appointed as agent by this document, and that I am not a health-care provider, nor an employee of a health-care provider or facility. I am not related to the principal by blood, marriage or adoption, and to the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

Signature of Witness

Date

Address

City

State

ALTERNATIVE NO. 2

State of _____

County of _____

On this _____ day of _____, in the year _____, before me,

_____ 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 he or she executed it. I declare under the 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.

Notary Seal

(Signature of Notary Public)

My commission expires: _____