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INFORMATION ABOUT MY SURROGATE DECISION-MAKER(S)

I, Hazel Smith, appoint Victor Smith, whose address is 111 Creighton Drive, Omaha, NE 68601, and whose telephone number(s) are: (home) 402-280-9999 (cell) 402-555-9999 as my surrogate decision-maker, known in this document as my "Attorney-in-Fact for Healthcare".

I appoint Bradley Smith whose address is 111 Somewhere, California and whose telephone number(s) are: (home) 919-555-3333 (cell) 818-555-4444 as my successor surrogate decision-maker (known in this document as my "Attorney-in-Fact for Healthcare") if the person named above is unavailable or unwilling to make decisions on my behalf.

I authorize these individuals to receive information and to make healthcare and treatment decisions on my behalf if and when it is determined that I am unable to make my own decisions. I give them responsibility for advocating on my behalf for healthcare and treatment that represents my values, beliefs and preferences, and ensures my physical, emotional, and spiritual well-being.

SURROGATE DECISION-MAKING SCOPE

I understand that this Advance Directives document refers specifically to my general healthcare and treatment needs. Regarding my mental healthcare and treatment needs (check one below):

☒ I have not completed separate Advance Directives documents for my mental healthcare and treatment needs at this time, and direct the individuals named here to make decisions for my mental healthcare and treatment needs.

☐ I have completed separate Advance Directives documents for my mental healthcare and treatment needs. A copy is located: _____.

(Note: Talk with a member of your healthcare team if you would like information about completing Advance Directives documents for your mental health care and treatment needs.)

SHARING MY INFORMATION

In addition to the individuals listed above, I give my permission for the following people to be given information related to my healthcare and treatment:

NA

(Note: Due to privacy laws, healthcare facilities may need additional HIPAA Authorization forms completed in order to release your Protected Health Information.)

ADDITIONAL INSTRUCTIONS

I direct my surrogate decision-maker(s); my doctors and other healthcare providers to comply with the following instructions regarding my healthcare and treatment needs (check one of the options below):

☒ I have no specific instructions, and direct only that healthcare and treatment decisions made on my behalf reflect my values, beliefs and preferences.

☐ I have specific instructions included in the supplemental information I have provided in this Advance Directives document, and direct that these instructions be taken into consideration when making healthcare and treatment decisions on my behalf.

Person completing this form initial AJK Date: 8/12/2002

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LIVING WILL DECLARATION

I understand that this section of this Advance Directives document is a Living Will Declaration which tells my doctor or other healthcare providers and my surrogate decision-maker(s) about my preferences regarding life-sustaining treatments or procedures.

Please select from the following options:

☐ I choose **NOT TO** complete a Living Will Declaration at this time, and instruct my doctor, other healthcare providers and surrogate decision-maker(s) to make decisions regarding life-sustaining treatments or procedures that they believe are appropriate and in keeping with my values, beliefs and preferences.

☒ I choose **TO** complete the following Living Will Declaration at this time.

Please select one of the following options:

☐ **For Iowa residents:** I direct that my doctor and any person charged with the responsibility for my care be guided by this expression of my preferences. If I should have an incurable or irreversible condition that will result either in death within a relatively short period of time or a state of permanent unconsciousness from which, to a reasonable degree of medical certainty, there can be no recovery, it is my desire that my life not be prolonged by the administration of life-sustaining procedures. If I am unable to participate in my healthcare decisions, I direct my attending doctor to withhold or withdraw life-sustaining procedures that merely prolong the dying process and are not necessary to my comfort or freedom from pain.

☒ **For Nebraska residents:** I direct that my doctor and any person charged with the responsibility for my care be guided by this expression of my preferences. If I should lapse into a persistent vegetative state or have an incurable and irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of my attending doctor, cause my death within a relatively short time and I am no longer able to make decisions regarding my medical treatment, I direct my attending doctor, pursuant to the Rights of the Terminally Ill Act, to withhold or withdraw life-sustaining treatment that is not necessary for my comfort or to alleviate pain.

☐ **For anyone:** I would like to share the following information about my preferences for life-sustaining treatments or procedures as my personal Living Will Declaration.

Person completing this form initial AJK Date: 8/12/2002