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Minnesota Short Form Health Care Directive

This short form health care directive names the health care agent(s) I choose to speak for me if I am not able to make decisions about my own health. A long-form health care directive to more fully express your wishes and goals for care is also available.

This completed document will take place of any health care directives or health care power of attorney appointments completed in the past. This document does not apply to intrusive mental health treatments such as electroconvulsive therapy or neuroleptic medicines.

Part 1: Personal Information

Full name (first, middle, last): _____

Date of birth: _____

Address: _____

Phone number: _____

Part 2: Health Care Agent (Health Care Power of Attorney)

A health care agent is a person you pick to make medical decisions for you if you are not able to. Your health care agent(s) should be 18 years of age or older and willing to:

- Take on this role for you.
- Understand your values, goals, and health care choices.
- Follow your choices, even when they do not agree with them.
- Make decisions for you during hard times.

Choose one or two backup agents in case your primary agent is not available.

A health care agent can be anyone in your life that you trust. You cannot have your health care provider, or an employee of your health care provider, be your health care agent. However, they can be if they are related to you by blood, marriage, legal domestic partnership or adoption. You may choose your health care provider or employee of your health care provider to be a health care agent **only** 1) if they have agreed to be your agent **and** 2) you provide a clear reason for your choice here such as being related to you. _____

I appoint the following person(s) to be my health care agent (health care power of attorney) to make medical decisions for me if I am not able to.

Primary Health Care Agent:

Full name: _____

Relationship to you: _____

Address: _____

Phone number: (H)_____(C)_____(W)_____

Alternate Health Care Agent:

Full name: _____

Relationship to you: _____

Address: _____

Phone number: (H)_____(C)_____(W)_____

My health care agent can make all health care decisions on my behalf if I am not able to make medical decisions or communicate for myself. This includes agreeing to or refusing treatments, interpreting my instructions, review and release my medical records and personal files as needed for my health care, choose my care providers, and decide where I live and receive care based on my health care needs.

Additional powers you can give your health care agent. Initial your choices that apply:

☐ **Post-death decisions**: My health care agent can follow my wishes about organ and tissue donation. Based on my instructions, decide on burial, cremation or memorial arrangements, including selecting the funeral home and final resting place.

☐ **Continue as health care agent after relationship changes**: I want the person I have chosen as my health care agent to continue to act on my behalf even if our marriage or domestic partnership is legally ending or has ended.

☐ **Pregnancy decisions**: If I am pregnant, I want my agent to make decisions about my pregnancy. This may include deciding to continue my pregnancy through delivery based on their understanding of my values, preferences or instructions.

Part 3: Health Care Preferences

Use this space to briefly share your treatment preferences to help guide your health care team and loved ones. Make sure your decisions reflect your values. For example, you may include your most important goals if your health declines. Or include your wishes for CPR, breathing support, or other treatments:

Part 4: Signature and Witnesses

You need a witness when you sign this health care directive for this document to be legal. Sign this document with a notary public **or** two witnesses. Each signature must be dated and all the dates for the signatures must match.

I am of sound mind and age 18 or older. I agree with everything written in this document. I completed this health care directive document of my own free will.

Your signature: _____ Date:_____

If I cannot sign my name, I ask (print name) _____ to sign for me.

Signature of the person I asked to sign for me _____ Date: _____

Statement of witnesses: I know this to be the person identified in this document. I believe this person to be of sound mind and at least 18 years old. I believe this person completed this document voluntarily. I personally witnessed this person signing this document.

Option 1: Notary public:

In my presence on _____ (date), _____ (name of person completing this health care directive) acknowledged their signature on this document or acknowledged that they authorized the person signing this document to sign on their behalf. I am not named as a health care agent or alternate health care agent in this document.

In the state of Minnesota, County of: _____
(where document is signed)

Notary stamp:

Notary signature: _____

My commission expires (date): _____

Option 2: Witnesses: (If you use a notary, you do not need additional witnesses). Must be age 18 or older and not appointed as the health care agent or alternative agent in this document. Only one witness can be a provider or an employee of the provider giving direct care on the date this document is signed. If a witness is an employee or provider giving care on this date, their initials are indicated here_____.

Witness 1:

Printed Full Name: _____

Phone Number: _____

Signature: _____ Date:_____

Witness 2:

Printed Full Name: _____

Phone Number: _____

Signature:_____ Date:_____