LIFE CARE PLANNING

Advance Directives for Making Your Health Care Decisions

Provided by

The Office of Arizona Attorney General,

Kris Mayes

MAIL FORMS TO:

AZ Healthcare Directives Registry
2901 N. Central Ave. Ste. 1100
Phoenix AZ 85012
OR
Email:
azhdr@contexture.org
OR
Fax: 602-264-8823

This packet was last updated 08/2026

WHAT IS LIFE CARE PLANNING AND WHY IS IT SO IMPORTANT?

Life Care Planning is the process of deciding your medical wishes and who you want to carry them out, in case you are unable to do so. The documents in this packet are meant for you to express your wishes, whatever they may be, so you receive the treatment you want if you can no longer communicate. Hopefully, having your wishes clearly stated will help those close to you avoid the pain of trying to guess what you would or would not want done.

Life Care Planning is an important task for all of us, whether young or old, healthy or facing challenges. None of us knows what life has in store, so taking steps to tell our loved ones of our wishes can make all the difference on our end of life care. Through increased awareness and access to information, Arizonans of all ages can make their choices known about who will manage their medical affairs in the event of an emergency.

WHY DOES THE ARIZONA ATTORNEY GENERAL OFFER THESE FORMS?

The Arizona Attorney General's Office wants to make sure that all Arizonans have access to these free legal documents, all of which are in line with Arizona Law. The Attorney General's Office is just one of several places to get forms and information on life care planning. The Attorney General's Office is not recommending any particular choices but does urge you to think about these choices, discuss them with your loved ones, and complete the right documents for your situation.

The primary role of the Attorney General's Office is to provide legal representation to the State of Arizona, its agencies, and State officials acting in their official capacities. The Office cannot give legal advice or represent private citizens on personal legal matters. If you need help with a personal legal matter—such as filing a lawsuit, creating a will, or defending against a criminal charge—you may want to contact a private attorney.

TALKING WITH OTHERS ABOUT YOUR WISHES

You should consider the people that you can begin your life care planning conversations with. Your medical care is about you - start the conversations with those who can help you consider what medical treatments you may or may not want if you become incapacitated, or as you approach the end of your life.

- **Your Health Care Agent (the person you select to make health care decisions for you)**
- **Your Spouse, Children, Other Relatives, and Close Friends**
- **Your Doctor, Clergyperson and Others**

DOCUMENTS INCLUDED IN THIS PACKET

- **Life Care Planning Checklist**
  - This document lists out all the forms in the packet so that you can check off which ones you have completed. If you wish to register your documents with the Arizona Health Care Directives Registry, the checklist will let you know which forms are accepted.

- **Health Care Power of Attorney**
  - This form allows you to select a person to make future medical decisions for you if you become too ill to communicate or cannot make those decisions for yourself.

- **Living Will**
  - This form allows you to list out the type of medical treatments you do or do not want for your end of life care. It should go with your Health Care Power of Attorney form so your agent knows your wishes.

- **Mental Health Care Power of Attorney**
  - This form allows you to select a person to make future mental health care decisions for you in case you become incapable of making those decisions for yourself.

- **Prehospital Medical Care Directives (Do Not Resuscitate)**
  - This form needs to be on orange paper and should be signed by you and your doctor. It informs emergency medical technicians (EMTs) or first responders not to resuscitate you. Sometimes this is called a DNR – Do Not Resuscitate. Please note this is valid prior to going to a hospital, if admitted to a hospital they may require you to fill out another form for their hospital.

- **Registration Agreement**
  - If you would like to register your documents with the Arizona Health Care Directives Registry, you MUST fill out this form and submit it with your documents.

WHAT DOES THE LAW SAY?

If you are interested in the laws written about the forms in this packet you can look them up at www.azleg.gov/arstitle/

- **Health Care Power of Attorney:** Arizona Revised Statutes §§ 36-3221 *et seq.*
- **Health Care Directives:** Arizona Revised Statutes §§ 36-3201 *et seq.*
- **Agents or Surrogate Decision-Makers:** Arizona Revised Statutes §§ 36-3231 *et seq*
- **Living Will:** Arizona Revised Statutes §§ 36-3201 *et seq* AND §§ 36-3261 *et seq.*
- **Mental Health Care Power of Attorney:** Arizona Revised Statutes §§ 36-3201 *et seq* AND §§ 36-3281 *et seq.*
- **Prehospital Medical Care Directives (Do Not Resuscitate):** Arizona Revised Statutes § 36-3251.

WHAT TO DO WITH THESE DOCUMENTS IN 4 STEPS

Step 1: Fill out all forms that apply to you and express your wishes for your end of life care.

Read through the documents carefully to select choices that are best suited to your wishes. Each document will need to be notarized OR witnessed. DO NOT have the documents signed by both, just pick one. If you do not know a notary or cannot pay for one a witness is legally accepted. It is important to note that verbal consents cannot be used in place of a signature or mark.

Witnesses or Notary Public CANNOT be anyone who is:

(a) under the age of 18
(b) related to you by blood, adoption, or marriage
(c) entitled to any part of your estate
(d) appointed as your agent
(e) involved in providing your health care at the time this form is signed

Step 2: Keep the originals in a safe place that is easily accessible.

It is important to review your documents from time to time. Give copies to the person you choose as your agent, as well as your doctor and anyone else who may be contacted about your wishes, such as family members and close friends. Keep a few extra copies and be sure to take one with you if you go to a hospital or other health care provider.

Step 3: Register your documents on the Arizona Health Care Directives Registry. *(Optional)*

You can mail, email or fax copies of the documents and the registration form to the registry. The information to send the documents to is on the cover of this packet and below.

AZ Healthcare Directives Registry
2901 N. Central Ave. Ste. 1100
Phoenix AZ 85012
OR
Email: azhdr@contexture.org OR Fax: 602-264-8823

The purpose of registering Life Care Planning forms is to create a centralized location where your relatives, first responders, a hospital, or other health care facility can access the forms if they are not readily available.

Step 4 – If Needed: Replacing Existing Directives.

To make changes to your existing documents, you will need to complete any forms that are affected by that change, i.e. change of address, wishes, or agent. It is important that you have a list of people with copies of your documents so that you can send them all an updated version if needed or a letter revoking the forms. The state will accept the most recent version of your documents.

If you have registered your documents with the Registry, you will need to fill out another registration form and indicate that you are replacing, adding, or revoking documents in the Registry.

LIFE CARE PLANNING IN OTHER STATES

- If you have advance directives from another state, district, or territory of the US, Arizona Revised Statutes §§ 36-3208 *et seq* says it is *"valid in this state if it was valid in the place where and at the time when it was adopted and only to the extent that it does not conflict with the criminal laws of this state."*
- If you have Arizona advance directives, you will need to check with the Attorney General's Office in the other state to find out if they accept Arizona's documents.

FREQUENTLY ASKED QUESTIONS:

1. **Where can I find these free forms?**
   - You can get copies of this Life Care Planning packet and the individual forms on the Attorney General's website at https://www.azag.gov/seniors/life-care-planning, or by calling the Community Outreach and Education Section at 602-542-2123.

2. **If I do not fill out these forms who will make medical decisions for me?**
   - If you did not leave a Health Care Power of Attorney and there is no court appointed guardian, health care providers will contact the following people, in this order, who will have the authority to make health care decisions for you.
   - These people are called "surrogates."
     1. Your spouse, unless you and your spouse are legally separated.
     2. Your adult child. If there is more than one adult child, the health care providers will seek the consent of a majority of the children who are available for consultation.
     3. Your parent.
     4. Your domestic partner if no other person has assumed any financial responsibility for you.
     5. Your brother or sister.
     6. Your close friend.

3. **Should I complete a Do Not Resuscitate "DNR" Form?**
   - If you are healthy and strong, you may not wish to complete a DNR. You can express your wishes about how you want to be cared for should you become seriously ill without completing a DNR. DNRs are most appropriate for people who would probably not do well with CPR (cardiopulmonary resuscitation) because they are very sick, terminally ill or otherwise extremely weak. In any case, you will need to discuss the DNR with your doctor, who will also need to sign the form.

4. **At what age should I think about filling out these documents?**
   - Now, so long as you are at least 18 years of age. It is never too early to be prepared.

5. **Will I need a lawyer to fill out these forms?**

- No. You do not need a lawyer's help to fill out these documents, but you may wish to consult with a lawyer if you need advice. If you need to find an attorney, you can reach out to these legal services for help:

- **Arizona State Bar**
  - **(602) 252-4804 or www.azbar.org**

  For help finding an attorney in your budget, area, and skill in the type of help needed.

- **24-hour Senior HELP LINE**
  - Within Maricopa County - **(602) 264-HELP / (602) 264-4357**
  - Outside Maricopa County – toll free - **1-888-264-2258**.

  There are Area Agency on Aging regional offices designated to serve each Arizona county. See your local telephone book for the closest regional office or go to www.des.az.gov and search Area Agency on Aging for locations.

WALLET-SIZED NOTICE:

Complete and cut out the notice below. Keep it in your wallet with your driver's license and insurance cards so that law enforcement and medical personnel will know who to contact for copies of your advanced directives.

NOTICE IN CASE OF ACCIDENT OR EMERGENCY:
My Name:
Date:

I have signed the following forms: (check)
□ Health Care Power of Attorney
□ Living Will
□ Mental Health Care Power of Attorney
□ Prehospital Medical Directive (Do Not Resuscitate)

Please contact the following for copies:
Name:
Telephone:

LIFE CARE PLANNING CHECKLIST

- ☐ Registration Agreement
  - This form HAS to be included if you want to register ANY forms.
- ☐ Health Care Power of Attorney
- ☐ Living Will
- ☐ Mental Health Care Power of Attorney
- ☐ Prehospital Medical Care Directive (Do Not Resuscitate)

To register your completed documents, make photo copies and send the copies to:

AZ Healthcare Directives Registry
2901 N. Central Ave. Ste. 1100
Phoenix AZ 85012
OR
Email: azhdr@contexture.org
OR
Fax: 602-264-8823

Healthcare Directives Registry
Arizona
a contexture® solution.

REGISTRATION AGREEMENT

About this Agreement: The Arizona Department of Health Services (ADHS) has designated Health Current to operate the Arizona Healthcare Directives Registry ("**AzHDR**"). The AzHDR is a **free** registry that provides secure electronic storage and access to advance directives. This registry service is NOT the Health Current health information exchange (HIE).

PLEASE READ THIS DOCUMENT CAREFULLY. This is a legally binding agreement (the "Registration Agreement") between you ("you" or "your") and Health Current ("we" or "us") about your submission of documents to the AzHDR. If the instructions herein are not followed, your form(s) may be rejected.

How to complete this Agreement:

- Read the agreement and complete this form.
- Fill in **all** blank spaces on this form.
- Sign and date form.
- Attach a copy of the witnessed or notarized advance directive(s). DO NOT SEND ORIGINALS TO THE AZHDR.
- Mail to: AzHDR – Health Current
  2901 N. Central Ave., Ste. 1100
  Phoenix, AZ 85012
- Or fax to: 602-264-8823
- Or email to: azhdr@contexture.org

Processing time: up to three weeks.

REQUIRED REGISTRANT INFORMATION

Last Name:	**First Name:**	**Middle Name:**
Address:		**Date of Birth:** MM/DD/YYYY
City:	**State:**	**Zip:**
Phone: ☐ I choose to opt out of SMS text	**Email:** ☐ I choose to opt out of email	
Mailing address if different from above:		
City:	**State:**	**Zip:**

Check the applicable box (check only one box per submission)**:**

☐ New registration.
☐ Replace an advance directive(s) presently in the AzHDR with the new one(s) attached.
  ☐ Replace all documents presently in the registry with the new one(s) attached.
  ☐ Replace only the following document type(s) presently in the registry with the new one(s) attached while leaving the others in place (check all that apply):
    ☐ Living will ☐ Health care power of attorney ☐ Mental health care power of attorney ☐ DNR
☐ Add an additional document to my currently stored directive(s).
☐ Inactivate my account: Check this box if you do not want your documents to be active in the registry.
☐ Change registrant demographic information previously submitted (update your information on this form).

Please note: All documents submitted to Health Current must be copies. Please do not submit originals. Once your account has been activated and your documents have been uploaded to the AzHDR, Health Current will not retain paper copies of your advance directives. Additionally, any documents received by Health Current that are not advance directives or attachments thereto will not be accepted and will be shredded and securely destroyed.

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Arizona Advance Directives Registration Agreement
Terms & Conditions

1. The AzHDR. The AzHDR is a free online registry for securely storing and accessing advance directives electronically. The Arizona Department of Health Services ("ADHS") has designated Health Current to operate the AzHDR. (*see* A.R.S. §§ 36-3291 through 3297). Health Current has contracted with a technology vendor(s) ("Vendor") to power this service. Use of the AzHDR is voluntary. Your decision to submit (or not submit) documents to the AzHDR will **NOT** affect the validity or revocation of any advance directives. While Health Current and its Vendor enable individuals to submit, store and access advance directives, Health Current and its Vendor do not take any part in, and are not responsible for, whether or how these advance directives are used or any interactions between you and third parties.

2. Submitting Advance Directives.

(a) Advance Directives. The documents that may be submitted to the AzHDR are limited to health care powers of attorney, mental healthcare powers of attorney, living wills, and prehospital medical care directives, as well as any attachments and any amendments thereto (collectively, "advance directives"). Arizona law requires that documents submitted to the AzHDR be notarized or witnessed. **You must NOT submit any original documents to the AzHDR. Original documents may not be returned. All documents submitted must be copies. Once accessible in the AzHDR, any paper documentation submitted to Health Current will be shredded and securely destroyed. Health Current will not retain paper copies of your advance directives.**

(b) Representation and Warranty. You represent and warrant that the information you provide to us is accurate, current and complete. This is an ongoing representation and warranty. You must not misrepresent your identity, provide false information, impersonate another person, or misrepresent your relationship with a person.

(c) Consent. By submitting documents to the AzHDR, you are giving your permission for Health Current to store these documents and make them accessible to third parties subject to applicable law. You must follow all the laws that apply to you regarding the release of information to the AzHDR. You are solely responsible for obtaining and any all consents or authorizations that you determine are required by the laws that apply to you to release information (including without limitation advance directives) to the AzHDR (collectively, "Consent").

(d) Activation. You acknowledge and agree that in order to activate your submission of an advance directive to the AzHDR, we must receive confirmation that the information submitted is correct. We may ask you for that confirmation. If applicable to your submission, you acknowledge, agree and authorize Health Current to provide your submission and the details surrounding that submission to the person who is the subject of the advance directive. You further authorize us to contact that person using the contact information you have provided to us. For example, if you are submitting an advance directive for another person, and you give us that person's physical address, email address or telephone phone number, you authorize us to use that contact information to inform that person that you have submitted an advance directive about that person.

(e) Identity Verification. Before we activate your document submission(s), we will also require you to verify your identity. In order to do that, you will be required to provide certain personal information about yourself and may be asked to provide personal information about the person who is the subject of the advance directive if you are submitting the advance directive for someone other than yourself. If you submit this Agreement and your advance directive by fax or mail to Health Current, you will be required to have your signature notarized to verify your identity. By signing this agreement before a notary public, you hereby consent to this form of identity verification. You represent and warrant that you have obtained any and all Consents to provide personal information about another person as part of your submission.

(f) No Document Validation. You acknowledge that Health Current has no obligation to pre-screen, verify or validate the advance directive(s) or any other documents you submit to the AzHDR; however, we reserve the right in our sole discretion to pre-screen, refuse to activate, or remove any document if it violates this Registration Agreement or is otherwise objectionable.

3. Accessing Advance Directives.

(a) Your AzHDR Account. Once we receive your document submission, we will create an AzHDR account that you can claim by registering with us at signup.azhdr.org. You may review, retrieve, revoke and replace documents through your AzHDR account or by contacting us at azhdr@contexture.org. It may take up to three weeks for us to process a request. A revocation or replacement is not effective until it is processed, and it will not affect any access, disclosure, use or other action taken in reliance on a previously submitted document before the effective date of the change.

(b) Security. Health Current uses industry standard safeguards to ensure the security, privacy and integrity of the AzHDR, but we need your help. You must protect your AzHDR account information and credentials. Health Current and its Vendor will not be responsible for any loss or damage caused by someone else using your account.

(c) Privacy. Health Current will not use or disclose information we maintain for the AzHDR except as allowed by state or federal law, including the AzHDR Confidentiality Law (see A.R.S. § 36-3295). Please read the Privacy Policy on the AzHDR website (azhdr.org) to learn how information about you is collected, used, and shared in connection with the AzHDR. By signing this Registration Agreement or by submitting documents to the AzHDR, you are also agreeing to the Privacy Policy. The Privacy Policy (and changes to it) are incorporated by reference into these Terms & Conditions.

(d) DISCLAIMER. HEALTH CURRENT AND ITS VENDOR DO NOT GUARANTEE THAT INFORMATION (INCLUDING WITHOUT LIMITATION ADVANCE DIRECTIVES) ON OR ACCESSIBLE THROUGH THE AZHDR WILL BE ACCURATE, COMPLETE, TIMELY (REAL TIME OR CONTINUOUSLY), ERROR-FREE, SECURE, OR WITHOUT INTERRUPTIONS, OR THAT ANY ERRORS WILL BE CORRECTED. YOU UNDERSTAND AND AGREE THAT THE AZHDR IS PROVIDED "AS IS" AND "AS IS AVAILABLE" WITH ALL FAULTS. NEITHER HEALTH CURRENT NOR VENDOR SHALL BE LIABLE FOR THE LOSS, DESTRUCTION OR UNAVAILABILITY OF ALL OR PART OF YOUR SUBMITTED DOCUMENTS.

4. Electronic Communications. By giving us your contact information, you are agreeing to receive communications, including without limitation calls, emails, text messages and notifications, from Health Current, Vendor and/or our affiliates about the document(s) you submitted and/or your use of the AzHDR, including without limitation notices and advisories. These communications may be done by automated dialing equipment and/or artificial voice or prerecorded messages. You may receive multiple messages each day. Standard message and data rates apply. We are not responsible for any data transmission fees. You can opt out at any time from receiving text messages by replying "STOP." This opt-out process does not apply to live phone calls or emails, which may continue in case we need to reach you.

5. Limitations of Liability. YOU UNDERSTAND AND AGREE THAT HEALTH CURRENT, ITS MEMBERS, OFFICERS, DIRECTORS, REPRESENTATIVES, EMPLOYEES, AGENTS, AFFILIATES, VENDOR AND BUSINESS PARTNERS (COLLECTIVELY, "HEALTH

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CURRENT PERSONNEL"), WILL NOT BE LIABLE TO YOU OR ANYONE ELSE FOR ANY INDIRECT, INCIDENTAL, CONSEQUENTIAL (INCLUDING WITHOUT LIMITATION LOST REVENUES OR LOST PROFITS), PUNITIVE, OR EXEMPLARY DAMAGES, PENALTIES, OR SPECIAL LIABILITY ARISING OUT OF OR IN ANY WAY CONNECTED WITH YOUR DOCUMENT SUBMISSIONS. IN NO EVENT WILL HEALTH CURRENT PERSONNEL'S LIABILTY ARISING OUT OF OR RELATED TO USE OF THE AZHDR EXCEED $50.00. ANY CAUSE OF ACTION OR CLAIM YOU MAY HAVE ARISING OUT OF OR IN ANY WAY CONNECTED TO YOUR DOCUMENT SUBMISSION MUST BE COMMENCED WITHIN ONE (1) YEAR AFTER THE CAUSE OF ACTION ACCRUES, OTHERWISE SUCH CAUSE OF ACTION OR CLAIM IS PERMANENTLY BARRED. YOU ACKNOWLEDGE AND AGREE THAT HEALTH CURRENT PERSONNEL ARE NOT LIABLE, AND YOU AGREE NOT TO SEEK TO HOLD THEM LIABLE, FOR THE CONDUCT OF THIRD PARTIES. THE FOREGOING LIMITATIONS WILL APPLY WHETHER SUCH DAMAGES, LIABILITY, CAUSES OF ACTION OR CLAIMS ARISE OUT OF BREACH OF CONTRACT, TORT (INCLUDING NEGLIGENCE), OR OTHERWISE, AND REGARDLESS OF WHETHER SUCH DAMAGES, LIABILITY, CAUSES OF ACTION OR CLAIMS WERE FORESEEABLE OR HEALTH CURRENT PERSONNEL WERE ADVISED OF THE POSSIBILITY OF SUCH DAMAGES, LIABILITY, CAUSES OF ACTION OR CLAIMS.

6. Indemnification and Release. YOU AGREE TO INDEMNIFY, DEFEND AND HOLD HARMLESS HEALTH CURRENT PERSONNEL FROM ANY AND ALL CLAIMS, DEMANDS, ACTIONS OF ANY KIND, LOSSES, EXPENSES, DAMAGES AND COSTS (INCLUDING WITHOUT LIMITATIONS REASONABLE ATTORNEYS' FEES) (COLLECTIVELY, "LOSSES") ARISING OUT OF OR IN ANY WAY CONNECTED WITH YOUR DOCUMENT SUBMISSIONS. You further agree to release Health Current Personnel and their successors from any and all Losses (including without limitation personal injuries and death) arising out of or in any way connected with the actions or omissions of third parties in connection with the AzHDR.

7. CLASS ACTION AND JURY TRIAL WAIVER. YOU AGREE THAT DISPUTES BETWEEN YOU AND HEALTH CURRENT OR ITS VENDOR WILL BE RESOLVED IN ACCORDANCE WITH THIS SUBMISSION AGREEMENT AND YOU WAIVE YOUR RIGHT TO PARTICIPATE IN A CLASS OR COLLECTIVE ACTION LAWSUIT, OR CLASS OR COLLECTIVE ARBITRATION. YOU AND HEALTH CURRENT WAIVE ALL RIGHTS TO A JURY TRIAL AND ELECT INSTEAD TO HAVE A JUDGE RESOLVE THE DISPUTE.

8. Miscellaneous. If any provision of this Submission Agreement is found to be unenforceable or invalid, such provisions will be deleted without affecting the remaining provisions. Arizona law governs the interpretation of this Registration Agreement, and will apply if there are disputes. Disputes will be settled in Maricopa County, Arizona, and you agree to submit to the exclusive personal jurisdiction of state and federal courts located in Maricopa County, Arizona.

Registrant Attestation (NOTARIZATION REQUIRED)

By signing below, I certify that I have read, understand, and agree to this AzHDR Registration Agreement, including without limitation the Terms and Conditions contained herein. I understand that once a submitted document is activated, it may be accessible to healthcare providers for the provision of healthcare services. I acknowledge and affirm that:

- I am eighteen (18) years of age or older or am an emancipated minor.
- I signed and executed the accompanying advance directive(s) and did so willingly (or willingly directed another to sign for me) as my free and voluntary act for the purposes therein expressed;
- The information provided is true and accurate to the best of my knowledge.

Signature: _____ Date: _____

Printed Name of Signer: _____

Select the one that applies:

☐ I am the subject of the advance directive.

☐ I have the following relationship to the subject of the advance directive: _____

State of Arizona

County of _____

On this _____ day of _____, 20____, before me personally appeared _____ (name of signatory), whose identity was proved to me on the basis of satisfactory identification/evidence to be the person whose name is subscribed to this document.

(Seal)

_____
Signature of Notary Public

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PREHOSPITAL MEDICAL CARE DIRECTIVE

(DO NOT RESUSCITATE or DNR)

(IMPORTANT – THIS DOCUMENT MUST BE ON PAPER WITH ORANGE BACKGROUND)

MAKE SURE YOU DISPLAY THIS FORM AS VISIBLY AS POSSIBLE FOR FIRST RESPONDERS

GENERAL INFORMATION AND INSTRUCTIONS: A Prehospital Medical Care Directive is a document signed by you and your doctor that informs emergency medical technicians (EMTs) or hospital emergency personnel not to resuscitate you. Sometimes this is called a DNR – Do Not Resuscitate. If you have this form, EMTs and other emergency personnel will not use equipment, drugs, or devices to restart your heart or breathing, but they will not withhold medical interventions that are necessary to provide comfort care or to alleviate pain.

You can either attach a picture to this form OR complete the personal information.

Please take the time to fill out a Health Care Power of Attorney form. That way, if you are unable to communicate your wishes, your agent can sign this form on your behalf, if that is your wish.

This form must be signed by you, in front of your witness or notary. Your Health Care Provider and your witness or notary must also sign this form. It is important to note that verbal consents cannot be used in place of a signature or mark.

DO NOT have the documents signed by both a witness and a notary, just pick one. If you do not know a notary or cannot pay for one, a witness is legally accepted.

Witnesses or notary public CANNOT be anyone who is:

(a) under the age of 18

(b) related to you by blood, adoption, or marriage

(c) entitled to any part of your estate

(d) appointed as your agent

(e) involved in providing your health care at the time this form is signed

IMPORTANT: Under Arizona law a Prehospital Medical Care Directive or DNR must be on letter sized paper or wallet sized paper on an orange background to be valid.

HEALTH CARE POWER OF ATTORNEY
Instructions and Information

GENERAL INSTRUCTIONS: Use this form if you want to select a person, called an "agent", to make future health care decisions for you so that if you become too ill or cannot make those decisions for yourself the person you choose and trust can make medical decisions for you. Be sure you understand the importance of this document. It is a good idea to talk to your doctor and loved ones if you have questions about the type of health care you do or do not want. It is recommended to clearly specify the order of persons who will serve as alternate executors or agents in your planning documents.

AUTOPSY CHOICE: If there is no legal reason to require an autopsy, you can decide if you want one done when you die, or whether you want your agent to choose for you. There is usually a charge for voluntary autopsies. You can help your family and loved ones by making your preferences on this topic clear. For additional information on autopsies please review Arizona Revised Statutes §§ 11-591 and 11-597.

ORGAN DONATION CHOICE (OPTIONAL): You can determine if you want to donate organs or tissues, and if you do, what organs or tissues you want to donate, for what purposes, and to what organizations. You also have the option of whole-body donation for research purposes. You can also choose to have your agent decide. For additional information on Organ Donation, please review Arizona Revised Statutes §§ Title 36, Chapter 7, Article 3 for the laws that pertain to it.

FUNERAL AND BURIAL CHOICE (OPTIONAL): You can determine, your funeral and burial choices in this form. You can select if, upon your death, you would like to be buried and where, or if you would like to be cremated and where your ashes will go, or you can select your agent to make that choice.

If you fill out this form, make sure you **DO NOT SIGN UNTIL** your witness or a notary public is present to watch you sign it.

PLEASE NOTE: At least one adult witness, not to include the proxy if there is one, OR a notary public must witness you signing this document.

DO NOT have the documents signed by both a witness and a notary, just pick one. If you do not know a notary or cannot pay for one, a witness is legally accepted.

Witnesses or notary public CANNOT be anyone who is:

(a) under the age of 18
(b) related to you by blood, adoption, or marriage
(c) entitled to any part of your estate
(d) appointed as your agent
(e) involved in providing your health care at the time this form is signed

OFFICE OF THE ARIZONA ATTORNEY GENERAL
KRIS MAYES

Health Care Power of Attorney

My Information (I am the "Principal"):

Name: _____ Date of Birth: _____

Address: _____ Phone: _____

_____ Email: _____

Selection of my health care power of attorney and alternate(s):

I choose the following person to act as my agent to make health care decisions for me:

Name: _____ Home Phone: _____

Address: _____ Work Phone: _____

_____ Cell Phone: _____

I choose the following person to act as an alternate (1) to make health care decisions for me if my first agent is unavailable, unwilling, or unable to make decisions for me:

Name: _____ Home Phone: _____

Address: _____ Work Phone: _____

_____ Cell Phone: _____

I choose the following person to act as an alternate (2) to make health care decisions for me if my second agent is unavailable, unwilling, or unable to make decisions for me:

Name: _____ Home Phone: _____

Address: _____ Work Phone: _____

_____ Cell Phone: _____

I AUTHORIZE my agent to make health care decisions for me when I cannot make or communicate my own health care decisions. I want my agent to make all such decisions for me except any decisions that I have expressly stated in this form that I do not authorize him/her to make. My agent should explain to me any choices he or she made if I am able to understand. I further authorize my agent to have access to my "personal protected health care information and medical records". This appointment is effective unless it is revoked by me or by a court order.

Health care decisions that I expressly DO NOT AUTHORIZE if I am unable to make decisions for myself: (Explain or write in "None")

_____

_____

My specific wishes regarding autopsy (additional information on page 1):

*Please note that if not required by law a voluntary autopsy may cost money. Initial your choice.

_____: Upon my death I DO NOT consent to a voluntary autopsy.

_____: Upon my death I DO consent to a voluntary autopsy.

_____: My agent may give or refuse consent for an autopsy.

Organ Donation

Please check one box only

□ Yes. Upon my death, I choose to donate my organs, tissues and eyes to help others (check box to indicate yes). By checking this box, I authorize any temporary medical procedures necessary to evaluate or preserve my organs and tissues, regardless of other healthcare decisions.

My donation is for the following purposes (strike a line through any of the following you do not want):

(a) Transplant and Therapy
(b) Research and Education
If I have specific limits on the organs, tissues, or purposes of donation, they are noted below:
_____
_____

☐ I've already registered. I want that decision to be followed.

☐ Not at this time. I want my agent to make the decision whether to authorize organ or tissue donation on my behalf.

☐ No. I do not want to make an organ or tissue donation, and I do not want donation authorized on my behalf by any person.

If I have not named an agent or made a decision at this time about donation, I understand that Arizona law permits a family member or other specific individual to authorize donation on my behalf.

My specific wishes regarding funeral and burial disposition (additional information on page 1):

_____**:** My agent will make all funeral and burial decisions. (If checked, no additional information is required.)

_____: Upon my death, I direct my body to be buried. (Instead of cremated)

_____**:** Upon my death, I direct my body to be buried in/at:_____

_____**:** Upon my death, I direct my body to be cremated. _____

_____

_____**:** Upon my death, I direct my body to be cremated with my ashes to be

_____

Do you have a living will?

If you have a Living Will, **you must attach** the Living Will to this form. A blank Living Will is available on the Attorney General's website www.azag.gov. Initial below.

_____: I have SIGNED AND ATTACHED a completed Living Will to this Health Care Power of Attorney.

_____: I have NOT SIGNED a Living Will.

Do you have a POLST (Portable Medical Order)?

A **POLST** form is for when you become seriously ill or frail and toward the end of life. A blank POLST is available on the Attorney General's website www.azag.gov. Initial below.

_____: I have SIGNED AND ATTACHED a completed POLST to this Health Care Power of Attorney.

_____: I have NOT SIGNED a POLST.

Do you have a Prehospital Medical Care Directive – a type of Do Not Resuscitate form (DNR)?

A blank Prehospital Medical Care Directive or DNR is available on the Attorney General's website www.azag.gov. Initial below.

_____: I and my doctor or health care provider HAVE SIGNED a Prehospital Medical Care Directive or DNR on Paper with ORANGE background in the event that Emergency Medical Technicians or hospital emergency personnel are called and my heart or breathing has stopped.

_____: I have NOT SIGNED a Prehospital Medical Care Directive or DNR.

PHYSICIAN AFFIDAVIT (OPTIONAL)

You may wish to ask questions of your physician regarding a particular treatment or about the options in the form. If you do speak with your physician it is a good idea to ask your physician to complete this affidavit and keep a copy for his/her file.

I, Dr. _____ have reviewed this document and have discussed with _____ any questions regarding the probable medical consequences of the treatment choices provided above. This discussion with the principal occurred on this day _____.

I have agreed to comply with the provisions of this directive.

_____
Signature of Physician

HIPAA WAIVER OF CONFIDENTIALITY FOR MY AGENT

_____ **(Initial)** I intend for my 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.

Revocability of this Health Care Power of Attorney: I retain the right to revoke all or any portion of this form or to disqualify any agent designated by me in this document.

MY SIGNATURE VERIFICATION FOR THE HEALTH CARE POWER OF ATTORNEY

My Signature (Principal): _____ Date: _____

If you are unable to physically sign this document, your witness/notary may sign and initial for you. If applicable have your witness/notary sign below.

Witness/Notary Verification: The principal of this document directly indicated to me that this Health Care Power of Attorney expresses their wishes and that they intend to adopt it at this time.

Witness/Notary Signature: _____

Name Printed: _____ Date: _____

SIGNATURE OF WITNESS (See Page 1 for who CANNOT be a witness)

I was present when this form was signed (or marked). The principal appeared to be of sound mind and was not forced to sign this form. I affirm that I meet the requirements to be a witness as indicated on page one of the health care power of attorney form.

Witness Signature: _____ Date: _____

Name Printed: _____

Address: _____

OR

SIGNATURE OF NOTARY (See Page 1 for who CANNOT be a Notary)

Notary Public (NOTE: If a witness signs your form, you SHOULD NOT have a notary sign):

NOTARIAL JURAT: Pertains to all five pages of this Health Care Power of Attorney Dated _____, 20_____.

STATE OF ARIZONA) ss

COUNTY OF _____)

_____

Principal's Name

Subscribed and sworn (or affirmed) before me this _____ day of _____, 20 _____

Notary Public Signature: _____

My Commission Expires: _____

LIVING WILL (End of Life Care)
Instructions

GENERAL INSTRUCTIONS: Use this form to make decisions now about your medical care if you are ever in a terminal condition, a persistent vegetative state or an irreversible coma. You should talk to your doctor about what these terms mean.

The Living Will is your written directions to your health care power of attorney, also referred to as your "agent", your family, your physician, and any other person who might make medical care decisions for you if you are unable to communicate yourself.

It is a good idea to talk to your doctor and loved ones if you have questions about the type of care you do or do not want.

IMPORTANT: If you have a Living Will and a Health Care Power of Attorney, you must attach the Living Will to the Health Care Power of Attorney.

If you fill out this form, make sure you **DO NOT SIGN UNTIL** your witness or a notary public is present to watch you sign it.

PLEASE NOTE: At least one adult witness, not to include the proxy if there is one, OR a notary public must witness you signing this document.

DO NOT have the documents signed by both a witness and a notary, just pick one. If you do not know a notary or cannot pay for one a witness is legally accepted.

Witnesses or notary public CANNOT be anyone who is:
(a) under the age of 18
(b) related to you by blood, adoption, or marriage
(c) entitled to any part of your estate
(d) appointed as your agent
(e) involved in providing your health care at the time this form is signed

OFFICE OF THE ARIZONA ATTORNEY GENERAL
KRIS MAYES

Living Will

My Information (I am the "Principal"):

Name: _____ Date of Birth: _____

Address: _____ Phone: _____

_____ Email: _____

Some general statements about your health care choices are listed below. If you agree with one of the statements, you should initial that statement. Read all of these statements carefully BEFORE you initial your preferred statement. You can also write your own statement concerning life-sustaining treatment and other matters relating to your health care. You may initial any combination of paragraphs 1, 2, 3 and 4, BUT if you initial paragraph 5 the others should not be initialed.

_____ 1. If I have a terminal condition I do not want my life to be prolonged, and I do not want life-sustaining treatment, beyond comfort care, that would serve only to artificially delay the moment of my death.

**Comfort care* *is treatment given in an attempt to protect and enhance the quality of life without artificially prolonging life.*

_____ 2. If I am in a terminal condition or an irreversible coma or a persistent vegetative state that my doctors reasonably feel to be irreversible or incurable, I do want the medical treatment necessary to provide care that would keep me comfortable, but I DO NOT want the following:

_____ a. Cardiopulmonary resuscitation (CPR). For example: the use of drugs, electric shock and artificial breathing.

_____ b. Artificially administered food and fluids.

_____ c. To be taken to a hospital if at all avoidable.

_____ 3. Regardless of any other directions I have given in this Living Will, if I am known to be pregnant, I do not want life-sustaining treatment withheld or withdrawn if it is possible that the embryo/fetus will develop to the point of live birth with the continued application of life-sustaining treatment.

_____ 4. Regardless of any other directions I have given in this Living Will, I do want the use of all medical care necessary to treat my condition until my doctors reasonably conclude that my condition is terminal or is irreversible and incurable or I am in a persistent vegetative state.

_____ 5. I want my life to be prolonged to the greatest extent possible (If you initial here, you should not initial any of the others).

PLEASE NOTE: You can attach additional instructions on your medical care wishes that have not been included in this Living Will form. Initial or put a check mark by box A or B below. Be sure to include the attachment if you check B.

_____ A. I HAVE NOT attached additional special instructions about End of Life Care I want.

_____ B. I HAVE attached additional special provisions or limitations about End of Life Care I want.

MY SIGNATURE VERIFICATION FOR THE LIVING WILL

My Signature (Principal): _____ Date: _____

If you are unable to physically sign this document your witness/notary may sign and initial for you. If applicable, have your witness/notary sign below.

Witness/Notary Verification: The principal of this document directly indicated to me that this Living Will expresses their wishes and that they intend to adopt it at this time.

Witness/Notary Signature: _____

Name Printed: _____ Date: _____

SIGNATURE OF WITNESS

I was present when this form was signed (or marked). The principal appeared to be of sound mind and was not forced to sign this form.

Witness Signature: _____ Date: _____

Name Printed: _____

Address: _____

OR

SIGNATURE OF NOTARY

Notary Public (NOTE: If a witness signs your form, you SHOULD NOT have a notary sign):

NOTARIAL JURAT: Pertains to all three pages of this Living Will

Dated _____, 20_____.

STATE OF ARIZONA) ss

COUNTY OF _____)

_____

Principals Name

Subscribed and sworn (or affirmed) before me this _____ day of _____, 20 _____

Notary Public Signature: _____

My Commission Expires: _____

OFFICE OF THE ARIZONA ATTORNEY GENERAL
KRIS MAYES

Mental Health Care Power of Attorney

GENERAL INSTRUCTIONS: Use this form if you want to appoint a person, also referred to as your "agent", to make future mental health care decisions for you if you become incapable of making those decisions for yourself.

The decision about whether you are incapable can only be made by a specialist in neurology or an Arizona licensed psychiatrist or psychologist who will evaluate whether you can give informed consent. Be sure you understand the importance of this document. It is a good idea to talk to your doctor and loved ones if you have questions about the type of mental health care you do or do not want.

If you fill out this form, make sure you **DO NOT SIGN UNTIL** your witness or a notary public is present to watch you sign it. **PLEASE NOTE:** At least one adult witness OR a notary public must witness you signing this document.

DO NOT have the documents signed by both a witness and a notary, just pick one. If you do not know a notary or cannot pay for one, a witness is legally accepted.

Witnesses or notary public CANNOT be anyone who is:
(a) under the age of 18
(b) related to you by blood, adoption, or marriage
(c) entitled to any part of your estate
(d) appointed as your agent
(e) involved in providing your health care at the time this form is signed

My Information (I am the "Principal"):

Name: _____ Date of Birth: _____

Address: _____ Phone: _____

_____ Email: _____

Selection of my mental health care power of attorney and alternate:

I choose the following person to act as my agent to make mental health care decisions for me:

Name: _____ Home Phone: _____

Address: _____ Work Phone: _____

_____ Cell Phone: _____

I choose the following person to act as an alternate to make mental health care decisions for me if my first agent is unavailable, unwilling, or unable to make decisions for me:

Name: _____ Home Phone: _____

Address: _____ Work Phone: _____

_____ Cell Phone: _____

Mental health treatments that I AUTHORIZE if I am unable to make decisions for myself:

Here are the mental health treatments I authorize my agent to make for me if I become incapable of making my own mental health care decisions due to mental or physical illness, injury, disability, or incapacity. This appointment is effective unless and until it is revoked by me or by an order of a court. My agent is authorized to do the following which I have initialed or marked:

_____**:** To receive medical records and information regarding my mental health treatment and to receive, review, and consent to disclosure of any of my medical records related to that treatment.

_____**:** To consent to the administration of any medications recommended by my treating physician.

_____**:** To admit me to an inpatient or partial psychiatric hospitalization program.

_____**:** Other: _____

_____

_____

Mental health care treatments that I expressly DO NOT AUTHORIZE if I am unable to make decisions for myself: (Explain or write in "None")

_____

_____

Revocability of this Mental Health Care Power of Attorney: This mental health care power of attorney or any portion of it may not be revoked and any designated agent may not be disqualified by me during times that I am found to be unable to give informed consent. However, at all other times I retain the right to revoke all or any portion of this mental health care power of attorney or to disqualify any agent designated by me in this document.

HIPAA WAIVER OF CONFIDENTIALITY FOR MY AGENT

_____ **(Initial)** I intend for my 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 of 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.

MY SIGNATURE VERIFICATION FOR THE MENTAL HEALTH CARE POWER OF ATTORNEY

My Signature (Principal): _____ Date: _____

If you are unable to physically sign this document your witness/notary may sign and initial for you. If applicable, have your witness/notary sign below.

Witness/Notary Verification: The principal of this document directly indicated to me that this Health Care Power of Attorney expresses their wishes and that they intend to adopt it at this time.

Witness/Notary Signature: _____

Name Printed: _____ Date: _____

SIGNATURE OF WITNESS (See Page 1 for who CANNOT be a witness)

I was present when this form was signed (or marked). The principal appeared to be of sound mind and was not forced to sign this form. I affirm that I meet the requirements to be a witness as indicated on page one of the mental health care power of attorney form.

Witness Signature: _____ Date: _____

Name Printed: _____

Address: _____

OR

SIGNATURE OF NOTARY (See Page 1 for who CANNOT be a Notary)

Notary Public (NOTE: If a witness signs your form, you SHOULD NOT have a notary sign):

NOTARIAL JURAT: Pertains to all three pages of this State of Arizona Mental Health Care Power of Attorney dated _____, 20_____.

STATE OF ARIZONA) ss

COUNTY OF _____)

_____

Principal's Name

Subscribed and sworn (or affirmed) before me this _____ day of _____, 20 _____

Notary Public Signature: _____

My Commission Expires: _____

PREHOSPITAL MEDICAL CARE DIRECTIVE

(DO NOT RESUSCITATE or DNR)

(IMPORTANT – THIS DOCUMENT MUST BE ON PAPER WITH ORANGE BACKGROUND)

MAKE SURE YOU DISPLAY THIS FORM AS VISIBLY AS POSSIBLE FOR FIRST RESPONDERS

GENERAL INFORMATION AND INSTRUCTIONS: A Prehospital Medical Care Directive is a document signed by you and your doctor that informs emergency medical technicians (EMTs) or hospital emergency personnel not to resuscitate you. Sometimes this is called a DNR – Do Not Resuscitate. If you have this form, EMTs and other emergency personnel will not use equipment, drugs, or devices to restart your heart or breathing, but they will not withhold medical interventions that are necessary to provide comfort care or to alleviate pain.

You can either attach a picture to this form OR complete the personal information.

Please take the time to fill out a Health Care Power of Attorney form. That way, if you are unable to communicate your wishes, your agent can sign this form on your behalf, if that is your wish.

This form must be signed by you, in front of your witness or notary. Your Health Care Provider and your witness or notary must also sign this form.

DO NOT have the documents signed by both a witness and a notary, just pick one. If you do not know a notary or cannot pay for one, a witness is legally accepted.

Witnesses or notary public CANNOT be anyone who is:

(a) under the age of 18
(b) related to you by blood, adoption, or marriage
(c) entitled to any part of your estate
(d) appointed as your agent
(e) involved in providing your health care at the time this form is signed

IMPORTANT: Under Arizona law a Prehospital Medical Care Directive or DNR must be on letter sized paper or wallet sized paper on an orange background to be valid.

PREHOSPITAL MEDICAL CARE DIRECTIVE

In the event of cardiac or respiratory arrest, I refuse any resuscitation measures including cardiac compression, endotracheal intubation and other advanced airway management, artificial ventilation, defibrillation, administration of advanced cardiac life support drugs and related emergency medical procedures.

Patient's Printed Name: _____

Patient's Signature: _____Date: _____

***If I am unable to communicate my wishes, and I have designated a Health Care Power of Attorney, my elected Health Care agent shall sign:**

Health Care Power of Attorney Printed Name: _____

Health Care Power of Attorney Signature: _____

PROVIDE THE FOLLOWING INFORMATION OR ATTACH A RECENT PHOTO:

Date of Birth_____

Sex_____

Race_____

Eye Color _____

Hair Color _____

INFORMATION ABOUT MY DOCTOR AND HOSPICE (if I am in Hospice)**:**

Physician:_____Telephone: _____

Hospice Program, if applicable (name):_____

SIGNATURE OF DOCTOR OR OTHER HEALTH CARE PROVIDER (REQUIRED)

I have explained this form and its consequences to the signer and obtained assurance that the signer understands that death may result from any refused care listed above.

Signature of a Licensed Health Care Provider: _____

Date: _____

SIGNATURE OF WITNESS OR NOTARY (NOT BOTH)

I was present when this form was signed (or marked). The patient then appeared to be of sound mind and free from duress.

Witness Signature:_____Date: _____

NOTARIAL JURAT:

STATE OF ARIZONA) ss
COUNTY OF _____)

_____
Patient's Name/Health Care Power of Attorney Name

Subscribed and sworn (or affirmed) before me this _____ day of _____, 20 _____

Notary Public Signature: _____My Commission Expires: _____