

**Connecticut Appointment of
a Health Care Representative and Conservator and Living Will**

Signing Instructions

- This document must be signed in front of two witnesses and a notary public
- Before signing this document fill in all of your personal information and your agent's personal information highlighted in yellow; it is not necessary to designate a successor agent (just leave the successor information blank if there is no successor)
- Do not make any selections in the section entitled Anatomical Gift if you do not want to make an anatomical gift
- Once you are ready to sign this document in the presence of two witnesses and a notary public, initial (where preferred) on pages 1 and 3 and date, and sign the document on page 3 in the areas highlighted in green
- After reading the declaration on page 3, the witnesses should sign and print their names and addresses on page 4
- The witnesses should also fill in the date at the end of the sworn statement on page 4, and sign a second time and print their names before the notary public on page 4 of the document.
- The notary should then notarize the document at the bottom of page 4.
- Once the document is signed, keep it in a safe, fire-proof, place, but do not put it in a bank safe deposit box
- If possible, give a copy to your agent and let your agent know where the original is kept

DO NOT ALTER THE WORDING OF THIS DOCUMENT

THESE ARE MY HEALTH CARE INSTRUCTIONS.
MY APPOINTMENT OF A HEALTH CARE REPRESENTATIVE,
THE DESIGNATION OF MY CONSERVATOR OF THE PERSON
FOR MY FUTURE INCAPACITY
AND
MY DOCUMENT OF ANATOMICAL GIFT

To any physician or advanced practice registered nurse who is treating me: These are my health care instructions including those concerning the withholding or withdrawal of life support systems, together with the appointment of my health care representative, the designation of my conservator of the person for future incapacity and my document of anatomical gift. As my physician or advanced practice registered nurse, you may rely on these health care instructions and any decision made by my health care representative or conservator of my person, if I am incapacitated to the point when I can no longer actively take part in decisions for my own life, and am unable to direct my physician or advanced practice registered nurse as to my own medical care.

1. Living Will. I, _____, residing at _____, the author of this document, request that, if my condition is deemed terminal or if I am determined to be permanently unconscious, I be allowed to die and not be kept alive through life support systems. By terminal condition, I mean that I have an incurable or irreversible medical condition which, without the administration of life support systems, will, in the opinion of my attending physician or advanced practice registered nurse, result in death within a relatively short time. By permanently unconscious I mean that I am in a permanent coma or persistent vegetative state which is an irreversible condition in which I am at no time aware of myself or the environment and show no behavioral response to the environment. The life support systems which I do not want include, but are not limited to: artificial respiration, cardiopulmonary resuscitation and artificial means of providing nutrition and hydration. I do want sufficient pain medication to maintain my physical comfort even though that may shorten my remaining life. I do not intend any direct taking of my life, but only that my dying not be unreasonably prolonged. I wish to live out my last days at home rather than in a hospital, nursing home, or other health care institution if that would not impose an undue burden upon my family. These requests are made after careful reflection, while I am of sound mind, and are in accordance with my strong convictions and beliefs.

If I am pregnant:

(Place a check to indicate option (1) or (2) or specify alternative instructions after (3))

- _____ (1) I intend to accept life support systems if my doctor believes that doing so would allow my fetus to reach a live birth.
- _____ (2) I intend this document to apply without modifications.
- _____ (3) I intend this document to apply as follows:

2. **Release from Liability and Waiver of Claims.** On behalf of myself and my heirs and legal representatives, and all persons who in any way might claim by, under, or through me, I hereby release from liability, and waive any claims against, all persons (including any institutions) for acting in accordance with my directions and wishes as set forth above.

3. **Appointment of Health Care Representative.** I appoint my _____, _____ (“my health care representative”), residing at _____, telephone _____, to be my health care representative. If my attending physician or advanced practice registered nurse determines that I am unable to understand and appreciate the nature and consequences of health care decisions and unable to reach and communicate an informed decision regarding treatment, my health care representative is authorized to make any and all health care decisions for me, including (1) the decision to accept or refuse any treatment, service or procedure used to diagnose or treat my physical or mental condition, except as otherwise provided by law such as for psychosurgery or shock therapy, as defined in section 17a-540, and (2) the decision to provide, withhold or withdraw life support systems. I direct my health care representative to make decisions on my behalf in accordance with my wishes, as stated in this document or as otherwise known to my health care representative. In the event my wishes are not clear or a situation arises that I did not anticipate, my health care representative may make a decision in my best interests, based upon what is known of my wishes. The foregoing grant of authority shall be construed broadly and shall include, without limitation, the authority to sign on my behalf all forms, waivers and releases required for my admission to or treatment at any hospital, nursing home, or other health care institution; to receive, and to consent to the disclosure of, my medical and hospital records; to employ and to discharge any of my health care providers, and, in connection therewith, to move me from one jurisdiction to any other; to give or to withhold consent to any diagnostic, medical or surgical procedure, care, or treatment, including the withholding or withdrawal of life-sustaining procedures, medications, and artificial nutrition and hydration; to file insurance claims and to enforce the provisions of any insurance contract relating to my health care; to obligate me for the payment of all costs and expenses incurred in connection with my health care even though such costs and expenses may be uninsured; to execute any documents and to do all other things appropriate or helpful to exercising the authority given by this proxy which I would be able to do myself if I then possessed the capacity to do so. 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 and by providing this release, my Health Care Representative is acting as my personal representative pursuant to HIPAA.

If _____ is unwilling or unable to serve as my health care representative, I appoint _____, _____, residing at _____, telephone _____], to be my alternate health care representative.

3. **Appointment of Conservator.** If a conservator of my person should need to be appointed, I designate my _____, _____, residing at _____, telephone _____, be appointed my conservator. If _____ is unwilling or unable to serve as my conservator, I designate my [relationship], _____, residing at _____, telephone _____

_____, to be successor conservator. No bond shall be required of either of them in any jurisdiction.

4. Anatomical Gift. I hereby make this anatomical gift, if medically acceptable, to take effect upon my death.

I give: (check one only if you plan to make an anatomical gift)

- _____ (1) any needed organs or parts
- _____ (2) only the following organs or parts

to be donated for: (check one only if you plan to make an anatomical gift)

- (1) ___ any of the purposes stated in subsection (a) of section 19a-289j
- (2) ___ these limited purposes _____

These requests, appointments, and designations are made after careful reflection, while I am of sound mind. Any party receiving a duly executed copy or facsimile of this document may rely upon it unless such party has received actual notice of my revocation of it. This authorization shall not be affected by my subsequent disability or incompetence.

IN WITNESS WHEREOF, I have executed this instrument this _____ day of _____, 2020.

SIGNATURE OF PRINCIPAL

THIS DOCUMENT WAS SIGNED IN OUR PRESENCE BY THE ABOVE-NAMED _____, THE AUTHOR OF THIS DOCUMENT, WHO APPEARED TO BE EIGHTEEN YEARS OF AGE OR OLDER, OF SOUND MIND AND ABLE TO UNDERSTAND THE NATURE AND CONSEQUENCES OF HEALTH CARE DECISIONS AT THE TIME THE DOCUMENT WAS SIGNED. THE AUTHOR APPEARED TO BE UNDER NO IMPROPER INFLUENCE. WE HAVE SUBSCRIBED THIS DOCUMENT IN THE AUTHOR'S PRESENCE AND AT THE AUTHOR'S REQUEST AND IN THE PRESENCE OF EACH OTHER.

Witness' Signature: _____

Print Name: _____

Address: _____

Witness' Signature: _____

Print Name: _____

Address: _____

STATE OF _____)
) ss.:
COUNTY OF _____)

We, the subscribing witnesses, being duly sworn, say that we witnessed the execution of these health care instructions, the appointments of a health care representative, the designation of a conservator for future incapacity and a document of anatomical gift by the author of this document; that the author subscribed, published and declared the same to be the author's instructions, appointments and designation in our presence; that we thereafter subscribed the document as witnesses in the author's presence, at the author's request, and in the presence of each other; that at the time of the execution of said document the author appeared to us to be eighteen years of age or older, of sound mind, able to understand the nature and consequences of said document, and under no improper influence, and we make this affidavit at the author's request this _____ day of _____, 2020.

_____, Witness

Print Name: _____

_____, Witness

Print Name: _____

Subscribed and sworn to before me
on _____, 2020

Notary Public

My commission expires: _____