

Doctor and each health care agent you named of the change. You can cancel your advance instruction for mental health treatment while you are able to make and make known your decisions, by telling your doctor or other provider that you want to cancel it.

**Whom should I talk to about an advance directive?**

You should talk to those closest to you about an advance directive and your feelings about the health care you would like to receive. Your doctor or health care provider can answer medical questions. A lawyer can answer questions about the law. Some people also discuss the decision with clergy or other trusted advisors.

**Where should I keep my advance directive?**

Keep a copy in a safe place where your family members can get it. Give copies to your family, your doctor or other health/mental health care provider, your health care agent, and any close friends who might be asked about your care should you become unable to make decisions.

**What if I have an advance directive from another state?**

An advance directive from another state may not meet all of North Carolina's rules. To be sure about this, you may want to make an advance directive in North Carolina too. Or you could have your lawyer review the advance directive from the other state.

**Where can I get more information?**

Your health care provider can tell you how to get more information about advance directives by contacting:

*This document was developed by the North Carolina Division of Medical Assistance in cooperation with the Department of Human Resources Advisory Panel on Advance Directives 1991. Revised 1999.*



**Medical Care Decisions  
and Advance Directives  
What You Should Know**

**What are My Rights?**

**Who decides about my medical care or treatment?**

If you are 18 or older and have the capacity to make and communicate health care decisions, you have the right to make decisions about your medical/mental health treatment. You should talk to your doctor or other health care provider about any treatment or procedure so that you understand what will be done and why. You have the right to say yes or no to treatments recommended by your doctor or mental health provider. If you want to control decisions about your health/mental health care even if you become unable to make or to express them yourself, you will need an "advance directive."

**What is an "advance directive"?**

An advance directive is a set of directions you give about the health/mental health care you want if you ever lose the ability to make decisions for yourself. North Carolina has three ways for you to make a formal advance directive. One way is called a "living will"; another is called a "health care power of attorney"; and another is called an "advance instruction for mental health treatment."

**Do I have to have an advance directive and what happens if I don't?**

Making a living will, a health care power of attorney or an advance instruction for mental health treatment is your choice. If you become unable to make your own decisions; and you have no living will, advance instruction for mental health treatment, or a person named to make medical/mental health decisions for you ("health care agent"), your doctor or health/mental health care provider will consult with someone close to you about your care.

Fold Here

**Living Will**

**What is a living will?**

In North Carolina, a living will is a document that tells others that you want to die a natural death if you are terminally and incurably sick or in a persistent vegetative state from which you will not recover. In a living will, you can direct your doctor not to use heroic treatments that would delay your dying, for example by using a breathing machine ("respirator" or "ventilator"), or to stop such treatments if they have been started. You can also direct your doctor not to begin or to stop giving you food and water through a tube ("artificial nutrition or hydration").

**Health Care Power of Attorney**

**What is a health care power of attorney?**

In North Carolina, you can name a person to make medical/mental health care decisions for you if you later become unable to decide yourself. This person is called your "health care agent." In the legal document you name who you want your agent to be. You can say what medical treatments/mental health treatments you would want and what you would not want. Your health care agent then knows what choices you would make.

**How should I choose a health care agent?**

You should choose an adult you trust and discuss your wishes with the person before you put them in writing.

**Advance Instruction for Mental Health Treatment**

**What is an advance instruction for mental health treatment?**

In North Carolina, an advance instruction for mental health treatment is a legal document that tells doctors and health care providers what mental health treatments you would want and what treatments you would not want, if you later become unable to decide yourself. The designation of a person to make your mental health care decisions, should you be unable to make them yourself, must be established as part of a valid Health Care Power of Attorney.

**Other Questions**

**How do I make an advance directive?**

You must follow several rules when you make a formal living will, health care power of attorney or an advance instruction for mental health treatment. These rules are to protect you and ensure that your wishes are clear to the doctor or other provider who may be asked to carry them out. A living will, a health care power of attorney and an advance instruction for mental health treatment must be written and signed by you while you are still able to understand your condition and treatment choices and to make those choices known. Two qualified people must witness all three types of advance directives. The living will and the health care power of attorney also must be notarized.

**Are there forms I can use to make an advance directive?**

Yes. There is a living will form, a health care power of attorney form and an advance instruction for mental health treatment form that you can use. These forms meet all of the rules for a formal advance directive. Using the special form is the best way to make sure that your wishes are carried out.

**When does an advance directive go into effect?**

A living will goes into effect when you are going to die soon and cannot be cured, or when you are in a persistent vegetative state. The powers granted by your health care power of attorney go into effect when your doctor states in writing that you are not able to make or to make known your health care choices. When you make a health care power of attorney, you can name the doctor or mental health provider you would want to make this decision. An advance instruction for mental health treatment goes into effect when it is given to your doctor or mental health provider. The doctor will follow the instructions you have put in the document, except in certain situations, after the doctor determines that you are not able to make and to make known your choices about mental health treatment. After a doctor determines this, your Health Care Power of Attorney may make treatment decisions for you.

**What happens if I change my mind?**

You can cancel your living will anytime by informing your doctor that you want to cancel it and destroying all the copies of it. You can change your health care power of attorney while you are able to make and make known your decisions, by signing another one and telling your

## The Living Will

A Guide for North Carolinians -- Planning Your Estate

### Introduction.

What is a living will? A living will is a declaration that you desire to die a natural death. You do not want extraordinary medical treatment or artificial nutrition or hydration used to keep you alive if there is no reasonable hope of recovery. A living will gives your doctor permission to withhold or withdraw life support systems under certain conditions.

**The patient's rights.** You have a basic right to control the decisions about your medical care, including the decision to have extraordinary means or artificial nutrition or hydration withheld or withdrawn if your condition is terminal and incurable or if you are in a persistent vegetative state.

If you are competent and able to communicate, you may tell your doctor that you do not want extraordinary means or artificial nutrition or hydration used to keep you alive if there is no reasonable hope of recovery.

What happens if you are not competent or able to communicate this decision? You may decide ahead of time with a living will. If you do not have a living will, someone else may have to decide for you.

### A living will is a legal document.

Statutory requirements. You must follow certain requirements to make your living will legally effective.

- You must be at least 18 years old and of sound mind when you sign it.
- Your living will must contain specific statements.
- You must sign your living will in the presence of two qualified witnesses and either a notary public or the clerk of superior court.

**Required statements.** To be valid in North Carolina, your living will must contain two specific statements.

1. You must declare that you do not want your doctor to use extraordinary means or artificial nutrition or hydration to keep you alive if your condition is terminal and incurable or if you are in a persistent vegetative state (depending upon your instructions).

2. You must state that you know your living will allows your doctor to withhold or stop extraordinary medical treatment or artificial nutrition or hydration (depending upon your instructions).

Beware of using a living will form provided in a magazine article or distributed by national

organizations. These forms may not contain the statements required to make them valid in North Carolina.

**Make clear, consistent choices.** You must instruct the doctor what you want done if your condition is terminal and incurable or if you are in a persistent vegetative state. You may make these choices in your living will by initialling the appropriate lines. If you make no choices, your living will is meaningless. If you make inconsistent choices, your living will is confusing and may not accomplish what you want. Read the choices carefully before initialling to make sure that your intentions are clear. An attorney can help you fill out the form correctly.

If your condition is terminal and incurable, your living will may instruct your doctor to do the following:

- to withhold or stop extraordinary means only, or
- to withhold or stop both extraordinary means and artificial nutrition or hydration.

If you are in a persistent vegetative state, your living will may instruct your doctor to do the following:

- to withhold or stop extraordinary means only, or
- to withhold or stop both extraordinary means and artificial nutrition or hydration.

**The living will must be signed, witnessed, and certified.** You must sign your living will in the presence of two witnesses:

- who are not related to you or your spouse;
- who will not inherit property from you, either under your will or under the laws that determine who will get your property if you do not have a will;
- who are not your doctor, your doctor's employees, or the employees of your hospital, nursing home or group-care home; and
- who do not have a claim against you.

Also, a notary public or a clerk or assistant clerk of superior court must certify your living will.

Statutory form. A copy of a living will, which is provided by Section 90-321, North Carolina General Statutes, is duplicated at the end of this publication. The law authorizing this form became effective Oct. 1, 1991. You should ask your attorney's advice before modifying the statutory form.

**Living wills signed under prior law.** What is the legal effect of a living will signed under prior law? A living will signed before Oct. 1, 1991, or signed using the old form is legally valid. However, the old living will does not mention being in a persistent vegetative state or the withholding or withdrawal of feeding tubes. If you want these possibilities covered, you should sign a new living will.

**How does a valid living will work?**

The living will gives your doctor permission to withhold or discontinue life support systems under two conditions. Under the first condition, you must be both terminally and incurably ill. Under the second condition, you must be diagnosed as being in a persistent vegetative state. If two doctors diagnose one of these conditions, your doctor may withhold or discontinue extraordinary medical treatment or artificial nutrition or hydration as directed by your living will.

**Definitions.**

*Artificial nutrition or hydration* describes the use of feeding tubes or other invasive means to give someone food or water.

*Extraordinary means or medical treatment* includes any medical procedure which artificially postpones the moment of death by supporting or replacing a vital bodily function.

You are considered to be in a *persistent vegetative state* if you have had a complete loss of self-aware cognition (you are a vegetable), and you will die soon without the use of extraordinary medical treatment or artificial nutrition or hydration.

**How do you revoke your living will?**

You may revoke your living will by communicating this desire to your doctor. You may use any means available to communicate your intent to revoke. Your mental or physical condition is not considered, so you do not need to be of sound mind. Someone acting on your behalf may also tell your doctor that you want to revoke your living will. Revocation is effective only after your doctor has been notified.

Destroying the original and all copies of your living will may revoke your living will as a practical matter. However, if you have discussed this issue with your doctor, be sure to tell your doctor that you have revoked your living will.

If you sign a new living will, be sure to revoke all prior living wills that may be inconsistent with your new living will.

**Where should you store your living will?**

Keep the original in a place where you or your family members may find it easily. Some lawyers suggest that you sign several copies and have each one witnessed and certified. Then, you may give an original to each of the appropriate people. However, if you change your mind and revoke your living will, make sure that you destroy all the original copies. (Note: North

Carolina law allows you to sign more than one original living will because signing a new living will does not revoke a previously signed living will.)

If you have named a health care agent, give him or her a copy of your living will. You may appoint a health care agent with a health care power of attorney or with a general durable power of attorney. Ask your lawyer for details. For more information about health care agents, read the North Carolina Cooperative Extension publication, Health Care Power of Attorney, FCS-387.

Give a copy of your living will to your doctor and any medical facility where you have regular appointments. Give a copy of your living will to your family so they understand your wishes. Also, carry a wallet card stating that you have a living will, where the original is located, and who to contact to get the original.

If you put the original of your living will in a lock box or safe deposit box, make sure someone knows where it is and has access to it. Otherwise, your living will may be found too late.

**What happens if you do not have a living will?**

If you do not have a living will and you are unable to make your medical decisions, someone else must decide for you. If two doctors diagnose that you are terminally and incurably ill or in a persistent vegetative state, extraordinary means or artificial nutrition or hydration may be withheld or stopped with the permission of:

- your guardian,
- your health care agent,
- your spouse, or  
the majority of your parents and children.

If you do not have a living will, your family is burdened with the decision. Your family may not be able to agree on what action to take. The lack of decision by your family may lengthen your suffering and increase your medical bills. A living will removes the decision from your family's shoulders and makes the decision yours.

**What is the effect of your living will if you move out of North Carolina?**

Different states have different laws on living wills, so your North Carolina living will may not be valid in another state. If you move to another state, check with an attorney there to see if you need to sign a new living will.

If you spend a lot of time in other states, you may want to sign a living will for each state. Before signing a living will from another state, ask an attorney if there is any reason why you should not sign a living will from that state. For example, you may not want to sign another state's living will if it revokes all previously signed living wills.

North Carolina Statutory Form, G.S. 90-321.

NORTH CAROLINA COUNTY OF \_\_\_\_\_

DECLARATION OF A DESIRE FOR A NATURAL DEATH

I, \_\_\_\_\_, being of sound mind, desire that, as specified below, my life not be prolonged by extraordinary means or by artificial nutrition or hydration if my condition is determined to be terminal and incurable or if I am diagnosed as being in a persistent vegetative state. I am aware and understand that this writing authorizes a physician to withhold or discontinue extraordinary means or artificial nutrition or hydration, in accordance with my specifications set forth below:

(Initial any of the following, as desired):

- \_\_\_ If my condition is determined to be terminal and incurable, I authorize the following:
  - \_\_\_ My physician may withhold or discontinue extraordinary means only.
  - \_\_\_ In addition to withholding or discontinuing extraordinary means if such means are necessary, my physician may withhold or discontinue either artificial nutrition or hydration, or both.
- \_\_\_ If my physician determines that I am in a persistent vegetative state, I authorize the following:
  - \_\_\_ My physician may withhold or discontinue extraordinary means only.
  - \_\_\_ In addition to withholding or discontinuing extraordinary means if such means are necessary, my physician may withhold or discontinue either artificial nutrition or hydration, or both.

This the \_\_\_\_\_ day of \_\_\_\_\_

Signature: \_\_\_\_\_

I hereby state that the declarant, \_\_\_\_\_, being of sound mind signed the above declaration in my presence and that I am not related to the declarant by blood or marriage and that I do not know or have a reasonable expectation that I would be entitled to any portion of the estate of the declarant under any existing will or codicil of the declarant or as an heir under the Intestate Succession Act if the declarant died on this date without a will. I also state that I am not the declarant's attending physician or an employee of the declarant's attending physician, or an employee of a health facility in which the declarant is a patient or an employee of a nursing home or any group-care home where the declarant resides. I further state that I do not now have any claim against the declarant.

Witness: \_\_\_\_\_

Witness: \_\_\_\_\_

CERTIFICATE

I, \_\_\_\_\_, Clerk (Assistant Clerk) of Superior Court or Notary Public (circle one as appropriate) for \_\_\_\_\_ County hereby certify that \_\_\_\_\_, the declarant, appeared before me and swore to me and to the witnesses in my presence that this instrument is his/her Declaration Of A Desire For A Natural Death, and that he/she had willingly and voluntarily made and executed it as his/her free act and deed for the purposes expressed in it.

I further certify that \_\_\_\_\_ and \_\_\_\_\_, witnesses, appeared before me and swore that they witnessed \_\_\_\_\_, declarant, sign the attached declaration, believing him/her to be of sound mind; and also swore that at the time they witnessed the declaration (i) they were not related within the third degree to the declarant or to the declarant's spouse, and (ii) they did not know or have a reasonable expectation that they would be entitled to any portion of the estate of the declarant upon the declarant's death under any will of the declarant or codicil thereto then existing or under the Intestate Succession Act as it provides at that time, and (iii) they were not a physician attending the declarant or an employee of an attending physician or an employee of a health facility in which the declarant was a patient or an employee of a nursing home or any group-care home in which the declarant resided, and (iv) they did not have a claim against the declarant. I further certify that I am satisfied as to the genuineness and due execution of the declaration.

This the \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_.

\_\_\_\_\_  
Clerk (Assistant Clerk) of Superior Court or Notary Public (circle one as appropriate) for the County of \_\_\_\_\_

Prepared by Carol A. Schwab, J.D., LL.M., a Member of the North Carolina State Bar, and a Family Resource Management Specialist for the North Carolina Cooperative Extension Service, North Carolina State University, Raleigh, North Carolina.

The North Carolina Cooperative Extension Service prepared this publication as a public service. It is designed to acquaint you with certain legal issues and concerns. It is not designed as a substitute for

legal advice, nor does it tell you everything you may need to know about this subject. Future changes in the law cannot be predicted, and statements in this publication are based solely on the laws in force on the date of publication. If you have specific questions on this issue, seek professional advice. If you need an attorney, you may call the North Carolina Lawyer Referral Service, a non-profit public service project of the North Carolina Bar Association, toll-free: 1-800-662-7660 (Wake County residents call: 828-1054).

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## Health Care Power of Attorney

### A Guide for North Carolinians -- Planning Your Estate

#### Introduction

You have the right to control the decisions about your medical care. To make these decisions, you must be competent and able to communicate. If you are not competent or able to communicate, someone else must make these decisions for you. A health care power of attorney allows you to choose this person. This publication explains what a health care power of attorney is and how it is used.

#### Health Care Power of Attorney

**What is it?** A health care power of attorney is a document that allows someone to make medical decisions for you if you cannot make them yourself. You must sign the document in the presence of two qualified witnesses, and it must be notarized. The form provided by Section 32A-25, North Carolina General Statutes, is duplicated at the end of this publication. Other forms may be used as long as they comply with the requirements of the statute. If you use a form, read and understand all provisions before signing. Your lawyer can explain and, if necessary, modify the available forms.

**Who may make a health care power of attorney?** You must be at least 18 years old, and you must be able to make and communicate health care decisions.

**Who may be appointed?** You may appoint any competent person who is at least 18 years old and who is not providing paid health care to you. The person you appoint is called your health care agent.

**How much authority does it give your health care agent?** You may give your health care agent the same power and authority as you have yourself to make your medical decisions. This includes the power to consent to your doctor giving, withholding or stopping any medical treatment, service or diagnostic procedure, including life-sustaining procedures.

You also may limit your health care agent's power. To make sure that your health care agent understands how you want everything handled, you may provide directions or guidelines as part of your health care power of attorney. However, limits on your health care agent's authority may reduce his or her ability to make necessary medical decisions on your behalf. Also, a too-complicated health care power of attorney may leave your doctor unsure as to which decisions may be made by your health care agent.

**When is it effective?** Your health care power of attorney is effective when a doctor states in writing that you lack sufficient understanding or capacity to make or communicate health care decisions. You may name the doctor or doctors you want to make this determination. If you do not name a doctor or if the doctors you name are unavailable, the doctor taking care of you may decide when it is effective.

#### How is a health care power of attorney revoked?

You may revoke your health care power of attorney at any time, so long as you are able to make and communicate your medical care decisions. The revocation may be in writing or by any means that you are able to communicate your intent to revoke to your doctor and health care agent. Also, you revoke a health care power of attorney by signing another health care power of attorney. Revocation is effective only after you have notified your doctor and each named health care agent. Finally, your death revokes your health care power of attorney.

#### What happens if your health care agent is unable or unwilling to act?

If your health care agent dies or becomes sick or incapacitated, or if he or she simply refuses to act, your health care power of attorney will have no legal effect. To avoid this problem, you may name one or more substitute health care agents. Your substitute health care agents will serve in the order you have listed them in your health care power of attorney.

#### How does a health care power of attorney work if you have given someone a durable power of attorney?

A durable power of attorney is a document used to give someone the legal authority to act on your behalf. A general durable power of attorney gives someone (called your "attorney-in-fact") broad powers to handle your affairs, including your property and finances. How does the health care power of attorney work if you have given someone a durable power of attorney?

You may include a health care power of attorney in your durable power of attorney. If you choose this method, the same person who has authority to handle your financial and other personal affairs will have the authority to make your health care decisions. One document covers everything.

Or, you may choose to name a health care agent in a separate health care power of attorney. A health care power of attorney does not affect the nonhealth care powers granted to your attorney-in-fact under a general durable power of attorney. However, if you give health care powers to both your attorney-in-fact and health care agent, your health care agent's power is superior.

For more information about durable powers of attorney, read the North Carolina Cooperative Extension publication, Legal Authority, FCS-363.

#### How does a health care power of attorney work if the court appoints a guardian?

If the court appoints a guardian of the person (someone to take care of your physical needs) or a general guardian (someone to take care of both you and your property), your health care power of attorney will cease to be effective. To protect your choice of health care agent, you may use your health care power of attorney to recommend that your health care agent be appointed as your

guardian of the person if you are declared legally incompetent. For more information about guardianship, read the North Carolina Cooperative Extension publication, Legal Authority, HE-363.

**Conclusion**

A health care power of attorney is the best assurance that your medical care will be handled the way you want it if you become unable to make

these decisions yourself. Simply telling your family what you want done is not enough. You need to give someone the legal right to make these decisions for you. Choose your health care agent carefully. He or she will have the right to make life and death decisions on your behalf. Make sure your health care agent understands your wishes. For guidance and more information, ask your attorney.

North Carolina Statutory Form, G.S. 32A-25

Health Care Power of Attorney

*(Notice: This document gives the person you designate your health care agent broad powers to make health care decisions for you, including the power to consent to your doctor not giving treatment or stopping treatment necessary to keep you alive. This power exists only as to those health care decisions for which you are unable to give informed consent.)*

*This form does not impose a duty on your health care agent to exercise granted powers, but when a power is exercised, your health care agent will have to use due care to act in your best interests and in accordance with this document. Because the powers granted by this document are broad and sweeping, you should discuss your wishes concerning life-sustaining procedures with your health care agent.*

*Use of this form in the creation of a health care power of attorney is lawful and is authorized pursuant to North Carolina law. However, use of this form is an optional and nonexclusive method for creating a health care power of attorney and North Carolina law does not bar the use of any other or different form of power of attorney for health care that meets the statutory requirements.)*

1. Designation of health care agent.

I, \_\_\_\_\_, being of sound mind, hereby appoint

Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

Home Telephone Number \_\_\_\_\_

Work Telephone Number \_\_\_\_\_

as my health care attorney-in-fact (herein referred to as my "health care agent") to act for me and in my name (in any way I could act in person) to make health care decisions for me as authorized in this document.

If the person named as my health care agent is not reasonably available or is unable or unwilling to act as my agent, then I appoint the following persons (each to act alone and successively, in the order named), to serve in that capacity: (Optional)

A. Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

Home Telephone Number \_\_\_\_\_

Work Telephone Number \_\_\_\_\_

B. Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

Home Telephone Number \_\_\_\_\_

Work Telephone Number \_\_\_\_\_

Each successor health care agent designated shall be vested with the same power and duties as if originally named as my health care agent.

2. Effectiveness of appointment.

*(Notice: This health care power of attorney may be revoked by you at any time in any manner by which you are able to communicate your intent to revoke to your health care agent and your attending physician.)*

Absent revocation, the authority granted in this document shall become effective when and if the physician or physicians designated below determine that I lack sufficient understanding or capacity to make or communicate decisions relating to my health care and will continue in effect during my incapacity, until my death. This determination shall be made by the following physician or physicians (You may include here a designation of your choice, including your attending physician, or any other physician. You may also name two or more physicians, if desired, both of whom must make this determination before the authority granted to the health care agent becomes effective.):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. General statement of authority granted.

Except as indicated in section 4 below, I hereby grant to my health care agent named above full power and authority to make health care decisions on my behalf, including, but not limited to, the following:

A. To request, review, and receive any information, verbal or written, regarding my physical or mental health, including, but not limited to, medical and hospital records, and to consent to the disclosure of this information;

B. To employ or discharge my health care providers;

C. To consent to and authorize my admission to and discharge from a hospital, nursing or convalescent home, or other institution;

D. To give consent for, to withdraw consent for, or to withhold consent for, X ray, anesthesia, medication, surgery, and all other diagnostic and treatment procedures ordered by or under the authorization of a licensed physician, dentist, or podiatrist. This authorization specifically includes the power to consent to measures for relief of pain.

E. To authorize the withholding or withdrawal of life-sustaining procedures when and if my physician determines that I am terminally ill, permanently in a coma, suffer severe dementia, or am in a persistent vegetative state. Life-sustaining procedures are those forms of medical care that only serve to artificially prolong the dying process and may include mechanical ventilation, dialysis, antibiotics, artificial nutrition and hydration, and other forms of medical treatment which sustain, restore or supplant vital bodily functions. Life-sustaining procedures do not include care necessary to provide comfort or alleviate pain.

I DESIRE THAT MY LIFE NOT BE PROLONGED BY LIFE-SUSTAINING PROCEDURES IF I AM TERMINALLY ILL, PERMANENTLY IN A COMA, SUFFER SEVERE DEMENTIA, OR AM IN A PERSISTENT VEGETATIVE STATE.

F. To exercise any right I may have to make a disposition of any part or all of my body for medical purposes, to donate my organs, to authorize an autopsy, and to direct the disposition of my remains.

G. To take any lawful actions that may be necessary to carry out these decisions, including the granting of releases of liability to medical providers.

4. Special provisions and limitations.

(Notice: The above grant of power is intended to be as broad as possible so that your health care agent will have authority to make any decisions you could make to obtain or terminate any type of health care. If you wish to limit the scope of your health care agent's powers, you may do so in this section.)

In exercising the authority to make health care decisions on my behalf, the authority of my health care agent is subject to the following special provisions and limitations (Here you may include any specific limitations you deem appropriate such as: your own definition of when life-sustaining treatment should be withheld or discontinued, or instructions to refuse any specific types of treatment that are inconsistent with your religious beliefs, or unacceptable to you for any other reason.):

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5. Guardianship provision.

If it becomes necessary for a court to appoint a guardian of my person, I nominate my health care agent acting under this document to be the guardian of my person, to serve without bond or security.

6. Reliance of third parties on health care agent.

A. No person who relies in good faith upon the authority of or any representations by my health care agent shall be liable to me, my estate, my heirs, successors, assigns, or personal representatives, for actions or omissions by my health care agent.

B. The powers conferred on my health care agent by this document may be exercised by my health care agent alone, and my health care agent's signature or act under the authority granted in this document may be accepted by persons as fully authorized by me and with the same force and effect as if I were personally present, competent, and acting on my own behalf. All acts performed in good faith by my health care agent pursuant to this power of attorney are done with my consent and shall have the same validity and effect as if I were present and exercised the powers myself, and shall inure to the benefit of and bind me, my estate, my heirs, successors, assigns, and personal representatives. The authority of my health care agent

pursuant to this power of attorney shall be superior to and binding upon my family, relatives, friends, and others.

7. Miscellaneous provisions.

A. I revoke any prior health care power of attorney.

B. My health care agent shall be entitled to sign, execute, deliver, and acknowledge any contract or other document that may be necessary, desirable, convenient, or proper in order to exercise and carry out any of the powers described in this document and to incur reasonable costs on my behalf incident to the exercise of these powers; provided, however, that except as shall be necessary in order to exercise the powers described in this document relating to my health care, my health care agent shall not have any authority over my property or financial affairs.

C. My health care agent and my health care agent's estate, heirs, successors, and assigns are hereby released and forever discharged by me, my estate, my heirs, successors, and assigns and personal representatives from all liability and from all claims or demands of all kinds arising out of the acts or omissions of my health care agent pursuant to this document, except for willful misconduct or gross negligence.

D. No act or omission of my health care agent, or of any other person, institution, or facility acting in good faith in reliance on the authority of my health care agent pursuant to this health care power of attorney shall be considered suicide, nor the cause of my death for any civil or criminal purposes, nor shall it be considered unprofessional conduct or as lack of professional competence. Any person, institution, or facility against whom criminal or civil liability is asserted because of conduct authorized by this health care power of attorney may interpose this document as a defense.

8. Signature of principal.

By signing here, I indicate that I am mentally alert and competent, fully informed as to the contents of this document, and understand the full import of this grant of powers to my health care agent.

\_\_\_\_\_ Date \_\_\_\_\_

Signature of Principal '(SEAL)'

9. Signatures of Witnesses.

I hereby state that the Principal, \_\_\_\_\_, being of sound mind, signed the foregoing health care power of attorney in my presence, and that I am not related to the principal by blood or marriage, and I would not be entitled to any portion of the estate of the principal under any existing will or codicil of the principal or as an heir under the Intestate Succession Act, if the principal died on this date without a will. I also state that I am not the principal's attending physician, nor an employee of the principal's attending physician, nor an employee of the health facility in which the principal is a patient, nor an employee of a nursing home or any group care home where the principal resides. I further state that I do not have any claim against the principal.

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

STATE OF NORTH CAROLINA

COUNTY OF \_\_\_\_\_

CERTIFICATE

I, \_\_\_\_\_, a Notary Public for \_\_\_\_\_ County, North Carolina, hereby certify that \_\_\_\_\_ appeared before me and swore to me and to the witnesses in my presence that his instrument is a health care power of attorney, and that he/she willingly and voluntarily made and executed it as his/her free act and deed for the purposes expressed in it.

I further certify that \_\_\_\_\_ and \_\_\_\_\_, witnesses, appeared before me and swore that they witnessed \_\_\_\_\_ sign the attached health care power of attorney, believing him/her to be of sound mind; and also swore that at the time they witnessed the signing (i) they were not related within the third degree to him/her or his/her spouse, and (ii) they did not know nor have a reasonable expectation that they would be entitled to any portion of his/her estate upon his/her death under any will or codicil thereto then existing or under the Intestate Succession Act as it provided at that time, and (iii) they were not a physician attending him/her, nor an employee of an attending physician, nor an employee of a health facility in which he/she was a patient, nor an employee of a nursing home or any group-care home in which he/she resided, and (iv) they did not have a claim against him/her. I further certify that I am satisfied as to the genuineness and due execution of the instrument.

This the \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_.

\_\_\_\_\_  
Notary Public

My Commission Expires:

(A copy of this form should be given to your health care agent and any alternate named in this power of attorney and to your physician and family members.)

Prepared by Carol A. Schwab, J.D., LL.M., a Member of the North Carolina State Bar, and a Family Resource Management Specialist for the North Carolina Cooperative Extension Service, North Carolina State University, Raleigh, North Carolina.

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Electronic Publication FCS-387

(Posted April 1997 - CAS)

**Advance Instruction for  
Mental Health Treatment**

**A Guide for North Carolinians**

Note: In 1998 the North Carolina General Assembly substantially modified this legislation. Consequently, the following publication is of historical interest only! A new publication is forthcoming.

**Introduction**

You have the right to control the decisions about your medical care. To make these decisions, you must be competent and able to communicate. If you are not competent or able to communicate, someone else must make these decisions for you. Advance instructions allow you to have some control in this situation.

In North Carolina, you may have a general health care power of attorney that covers all health care problems. If you wish, you may also have an advance instruction that covers only mental health care. This publication explains an advance instruction for mental health treatment. For more information on a general health care power of attorney, see the North Carolina Cooperative Extension Service publication, Health Care Power of Attorney, FCS-387.

**What is an advance instruction on mental health treatment?**

An advance instruction on mental health treatment allows you to give instructions and preferences regarding mental health treatment. It also allows you to appoint an agent to make these decisions for you when you are incapable of making them yourself. You must sign the document in the presence of two qualified witnesses. The form provided by §122C-77 of the North Carolina General Statutes is duplicated in this publication. Other forms may be used as long as they comply with the requirements of the statute. If you use a form, read and understand all provisions before signing. Your lawyer can explain and, if necessary, modify the available forms.

**Who may make an advance instruction for mental health?**

Any person of sound mind who is age 18 or over may make an advance instruction regarding mental health treatment. This person is called the "principal."

**When is it effective?**

An advance instruction becomes effective when it is delivered to your doctor or other mental health treatment provider. It remains valid until revoked or expired. It automatically expires in two years. If the principal is capable, he or she may revoke the advance instruction at any time in whole or in part. The revocation is effective when the principal notifies his or her doctor or other provider that it is revoked.

**What is the doctor's duty?**

The doctor must make the advance instruction part of the patient's medical record. The doctor must comply with it to the fullest extent possible, unless compliance is not consistent with

- Best medical practice to benefit the principal,
- Availability of the mental health treatments requested, and
- Applicable law.

If the doctor is unwilling to comply with part or all of the advance instruction for one or more of the reasons stated above, he or she must notify the principal or agent and must record the reason in the patient's medical record.

A doctor need not honor the advance instruction in cases of emergencies or involuntarily committed patients.

**How is an agent appointed?**

An advance instruction may name a competent adult to act as an agent to make decisions about mental health treatment. An alternate agent may also be named to act as agent if the first choice is unable or unwilling to act. An agent must accept the appointment in writing.

The following people may not serve as the agent:

- The principal's doctor or mental health service provider or an employee of the doctor or provider, if unrelated to the principal by blood, marriage, or adoption.
- An owner, operator, or employee of a health care facility, if unrelated to the principal by blood, marriage, or adoption.

**What is the agent's authority?**

The agent may make decisions about mental health treatment on behalf of the principal only when the principal is incapable. The principal is incapable when the doctor or psychologist determines that the principal currently lacks the capacity to make and communicate mental health treatment decisions.

The decisions of the agent must be consistent with the desires the principal has stated in the advance instruction. If the principal's desires are not stated in the advance instruction, the agent must act in good faith in the manner in which the agent believes the principal would act if he or she were capable.

**What are the agent's rights?**

The agent has the same rights as the principal to receive information about the proposed mental health treatment, and to receive, review, and consent to disclosure of medical records relating to that treatment.

The agent may withdraw as agent by giving notice to the principal. If the principal is incapable, the agent may withdraw by giving notice to the doctor or other provider. Notice of withdrawal may be oral, but it is preferable to put it in writing. The doctor or provider must note the agent's withdrawal in the principal's medical record.

**What is the agent's potential liability?**

The agent is not personally liable, as a result of acting as an agent, for the cost of treatment provided to the principal. The agent is not subject to criminal prosecution, civil liability, or professional disciplinary action for any action taken in good faith pursuant to an advance instruction.

**Who may witness it?**

An advance instruction for mental health treatment must be witnessed by two people who personally know the principal. Neither may be

- A person appointed as the agent;
- The principal's doctor or mental health service provider or a relative of the doctor or provider;
- The owner, operator, or relative of an owner or operator of a facility in which the principal is a patient or resident; or
- A person related to the principal by blood, marriage, or adoption.

**Conclusion**

The advance instruction for mental health treatment became effective in North Carolina on January 1, 1998. Ask your attorney for more information.

Author's note: The legislation creating the advance instruction for mental health treatment is the subject of much criticism and discussion. Efforts are currently being made to amend this legislation. For more information, read Schwab, Carol. "A Critical Analysis of North Carolina's Advance Instruction for Mental Health Treatment." The Forum for Family and Consumer Issues 3.1 (1998): 39 pars. 7 March 1998 <<http://www.ces.ncsu.edu/depts/fcs/pub/1998/aimht.html>>.

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Electronic Publication FCS-484.

(February 1998 - CAS)

**ADVANCE INSTRUCTION FOR MENTAL HEALTH TREATMENT**

I, \_\_\_\_\_, being an adult of sound mind, willfully and voluntarily make this advance instruction for mental health treatment to be followed if it is determined by a physician or eligible psychologist that my ability to receive and evaluate information effectively or communicate decisions is impaired to such an extent that I lack the capacity to refuse or consent to mental health treatment. 'Mental health treatment' means the process of providing for the physical, emotional, psychological, and social needs of the principal. 'Mental health treatment' includes electroconvulsive treatment (ECT), commonly referred to as 'shock treatment,' treatment of mental illness with psychotropic medication, and admission to and retention in a facility for care or treatment of mental illness.

I understand that psychoactive medications and electroconvulsive treatment (ECT) (commonly referred to as 'shock treatment') may not be administered without my express and informed written consent or, if I am incapable of giving my informed consent, the express and informed written consent of my legally responsible person, health care agent named pursuant to a valid health care power of attorney, or attorney-in-fact named pursuant to a valid advance instruction for mental health treatment, as required under G.S. 122C-57.

I understand that I may become incapable of giving or withholding informed consent for mental health treatment due to the symptoms of a diagnosed mental disorder. These symptoms may include: \_\_\_\_\_  
\_\_\_\_\_

**PSYCHOACTIVE MEDICATIONS**

If I become incapable of giving or withholding informed consent for mental health treatment, my instructions regarding psychoactive medications are as follows:

I consent to the administration of the following medications: \_\_\_\_\_  
\_\_\_\_\_

I do not consent to the administration of the following medications: \_\_\_\_\_  
\_\_\_\_\_

Conditions or limitations: \_\_\_\_\_  
\_\_\_\_\_

**ADMISSION TO AND RETENTION IN FACILITY**

If I become incapable of giving or withholding informed consent for mental health treatment, my instructions regarding admission to and retention in a health care facility for mental health treatment are as follows:

\_\_\_\_\_ I consent to being admitted to a health care facility for mental health treatment.

My facility preference is \_\_\_\_\_

\_\_\_\_\_ I do not consent to being admitted to a health care facility for mental health treatment.

This advance instruction cannot, by law, provide consent to retain me in a facility for more than 10 days.

Conditions or limitations: \_\_\_\_\_  
\_\_\_\_\_

**ADDITIONAL INSTRUCTIONS**

These instructions shall apply during the entire length of my incapacity.

In case of mental health crisis, please contact:

1. Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

Home Telephone Number: \_\_\_\_\_

Work Telephone Number: \_\_\_\_\_

Relationship to Me: \_\_\_\_\_

2. Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

Home Telephone Number: \_\_\_\_\_

Work Telephone Number: \_\_\_\_\_

Relationship to Me: \_\_\_\_\_

3. My Physician: \_\_\_\_\_

Name: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

4. My Therapist: \_\_\_\_\_

Name: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

The following may cause me to experience a mental health crisis: \_\_\_\_\_

\_\_\_\_\_

The following may help me avoid a hospitalization: \_\_\_\_\_

\_\_\_\_\_

I generally react to being hospitalized as follows: \_\_\_\_\_

\_\_\_\_\_

Staff of the hospital or crisis unit can help me by doing the following: \_\_\_\_\_

\_\_\_\_\_

I give permission for the following person or people to visit me: \_\_\_\_\_

\_\_\_\_\_

Instructions concerning any other medical interventions, such as electroconvulsive (ECT) treatment (commonly referred to as 'shock treatment'): \_\_\_\_\_

\_\_\_\_\_

Other instructions: \_\_\_\_\_

\_\_\_\_\_

I have attached an additional sheet of instructions to be followed and considered part of this advance instruction.

**ATTORNEY-IN-FACT**

I hereby appoint:

Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

Home Telephone Number: \_\_\_\_\_

Work Telephone Number: \_\_\_\_\_

to act as my attorney-in-fact to make decisions regarding my mental health treatment if I become incapable of giving or withholding informed consent for that treatment.

If the person named above refuses or is unable to act on my behalf, or if I revoke that person's authority to act as my attorney-in-fact, I authorize the following person to act as my attorney-in-fact:

Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

Home Telephone Number: \_\_\_\_\_

Work Telephone Number: \_\_\_\_\_

My attorney-in-fact is authorized to make decisions that are consistent with the instructions I have expressed in this advance instruction or, if not expressed, as are otherwise known by my attorney-in-fact, my attorney-in-fact is to act in what he or she believes to be my best interests.

If it becomes necessary for the court to appoint a guardian for me, I hereby nominate my attorney-in-fact to serve in that capacity.

By signing here, I indicate that I am mentally alert and competent, fully informed as to the contents of this document, and understand the full import of this grant of powers to my attorney-in-fact.

Signature of Principal \_\_\_\_\_ Date \_\_\_\_\_

**AFFIRMATION OF WITNESSES**

We affirm that the principal is personally known to us, that the principal signed or acknowledged the principal's signature on this advance instruction for mental health treatment in our presence, that the principal appears to be of sound mind and not under duress, fraud, or undue influence, and that neither of us is: (1) A person appointed as an attorney-in-fact by this document; (2) The principal's attending physician or mental health service provider or a relative of the physician or provider; (3) The owner, operator, or relative of an owner or operator of a facility in which the principal is a patient or resident; or (4) A person related to the principal by blood, marriage, or adoption.

Witnessed by:

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

STATE OF NORTH CAROLINA

COUNTY OF \_\_\_\_\_

**ACCEPTANCE OF APPOINTMENT AS ATTORNEY-IN-FACT**

I accept this appointment and agree to serve as attorney-in-fact to make decisions about mental health treatment for the principal. I understand that I have a duty to act consistent with the desires of the principal as expressed in this appointment. I understand that this document gives me authority to make decisions about mental health treatment only while the principal is incapable as determined by a qualified, crisis, services professional and a physician or eligible psychologist. I understand that the principal may revoke this advance instruction in whole or in part at any time and in any manner when the principal is not incapable.

Signature of Attorney-in-fact \_\_\_\_\_ Date \_\_\_\_\_

Signature of Alternative Attorney-in-fact \_\_\_\_\_ Date \_\_\_\_\_