

# Living Will Sample Alabama (aka "Advanced Medical Directive")

[Online Living Will Form \\$8.99 \(free trial\)--click here](#)

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## ADVANCE MEDICAL DIRECTIVE AND HEALTH CARE PROXY GIVEN BY JAMES ROBERT HEDGES

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This form may be used in the State of Alabama to make your wishes known about what medical treatment or other care you would or would not want if you become too sick to speak for yourself. You are not required to have an advance directive. If you do have an advance directive, be sure that your doctor, family, and friends know you have one and know where it is located.

### PART 1

#### Section 1. Living Will

I, JAMES ROBERT HEDGES, being of sound mind and at least 19 years old, would like to make the following wishes known. I direct that my family, my doctors and health care workers, and all others follow the directions I am writing down. I know that at any time I can change my mind about these directions by tearing up this form and writing a new one. I can also do away with these directions by tearing them up and by telling someone at least 19 years of age of my wishes and asking him or her to write them down.

I understand that these directions will only be used if I am not able to speak for myself.

#### DEFINITIONS:

**Terminally ill or injured** is when my doctor and another doctor decide that I have a condition that cannot be cured and that I will likely die in the near future from this condition.

**Life sustaining treatment** – Life sustaining treatment includes drugs, machines, or medical procedures that would keep me alive but would not cure me. I know that even if I choose not to have life sustaining treatment, I will still get medicines and treatments that ease my pain and keep me comfortable.

**Artificially provided food and hydration** (Food and water through a tube or an IV) – I understand that if I am terminally ill or injured I may need to be given food and water through a tube or an IV to keep me alive if I can no longer chew or swallow on my own or with someone helping me.

**Permanent unconsciousness** is when my doctor and another doctor agree that within a reasonable degree of medical certainty I can no longer think, feel anything, knowingly move, or be aware of being alive. They believe this condition will last indefinitely without hope for improvement and have watched me long enough to make that decision. I understand that at least one of these doctors must be qualified to make such a diagnosis.

Please see the specific decisions I have made under this Living Will in Part 2 of this form below.

Section 2. If I need someone to speak for me ("Health Care Proxy")

This form can be used in the State of Alabama to name a person you would like to make medical or other decisions for you if you become too sick to speak for yourself. This person is called a health care proxy. You do not have to name a health care proxy. The directions in this form will be followed even if you do not name a health care proxy.

Place an "X" by only one answer:

I do not want to name a health care proxy. (If you check this answer, go to Section 3)

I do want the person listed below to be my health care proxy. I have talked with this person about my wishes.

Designation of Proxy

I designate the following individual as my health care proxy: **Sara Jane Hedges** whose residence is 321 Home Street, Louisville, KY.

Instructions for Proxy

Place your initials next to either "yes" or "no":

I want my health care proxy to make decisions about whether to give me food and water through a tube or an IV.

Yes  No

Place your initials by only one of the following:

I want my health care proxy to follow only the directions as listed on this form.

I want my health care proxy to follow my directions as listed on this form and to make any decisions about things I have not covered in the form.

I want my health care proxy to make the final decision, even though it could mean doing something different from what I have listed on this form.

Section 3. The things listed on this form are what I want.

I understand the following:

If my doctor or hospital does not want to follow the directions I have listed in Part 2 below, they must see that I get to a doctor or hospital who will follow my directions.

If I am pregnant, or if I become pregnant, the choices I have made on this form will not be followed until after the birth of the baby.

If the time comes for me to stop receiving life sustaining treatment or food and water through a tube or an IV, I direct that my doctor talk about the good and bad points of doing this, along with my wishes, with my health care proxy, if I have one, and with the following people: \_\_\_\_\_ .

**Go to Part 2 below.**

**PART 2  
INSTRUCTIONS FOR HEALTH CARE**

I have the primary right to make my own decisions concerning treatment that might unduly prolong the dying process. By this declaration, I express to my physician, family and friends my intent.

(6) END-OF-LIFE DECISIONS: In cases where both (1) my attending physician determines that I am no longer able to understand, appreciate, and direct my medical treatment **and** (2) two physicians—one of whom is my attending physician and the other is qualified and experienced in making such diagnosis—have personally examined me and have diagnosed and document in my medical records that I am either terminally ill or that I am in a state of persistent unconsciousness with no reasonable expectation of recovery, I direct that my health-care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choices I have stated below. The word "Withhold" shall be used to mean both withholding the treatment if it has not yet been given and withdrawing the treatment if it is currently being administered.

* Artificially supplied nutrition and hydration (including tube feeding or food and water)	<b>Withhold</b>
* Surgery or other invasive procedures (i.e., those where medical instruments must enter the body)	<b>Withhold</b>
* Heart-lung resuscitation (CPR)	<b>Withhold</b>
* Antibiotics	<b>Do NOT Withhold</b>
* Kidney or Renal dialysis	<b>Withhold</b>
* Mechanical ventilator (respirator)	<b>Withhold</b>
* Chemotherapy and other radiation therapy	<b>Withhold</b>
* All other "life sustaining" medical procedures that are merely intended to keep me alive without reasonable hope of improving my condition	<b>Withhold</b>

**I hereby acknowledge the above choices:**

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**JAMES ROBERT HEDGES**

Declarant / Principal

(7) RELIEF FROM PAIN: I direct that I be given medical treatment to relieve pain or to provide comfort, even if such treatment might shorten my life, suppress my appetite or my breathing, or be habit-forming.

(8) HIPAA Privacy Authorization. I hereby authorize my Agent to execute any form authorization for use or disclosure of my Protected Health Information relating to past, present or future medical records required by the Health Insurance Portability and Accountability Act ("HIPAA"). My Agent is authorized to execute a HIPAA form authorization for release of my medical records in favor of any health provider or other party that the Agent deems appropriate.

**PART 3  
DONATION OF ORGANS AT DEATH  
(OPTIONAL)**

(10) ORGAN DONATION: Upon my death, I wish to donate any and all of my organs, tissues, or other bodily parts for

use in transplant to another human being. I authorize my health care agent to give consent to the medical organization of his choosing for donation of my aforementioned body parts.

**PART 4  
PRIMARY PHYSICIAN  
(OPTIONAL)**

(11) DESIGNATION OF PHYSICIAN: I designate the following physician as my primary physician: John Paul Jones, MD.

\* \* \* \* \*

(12) EFFECT OF COPY: A copy of this form has the same effect as the original.

(13) DURABILITY OF HEALTH CARE AGENT'S POWERS: This Health Care Power of Attorney is a durable power of attorney and the authority of my agent shall not terminate if I become disabled or incapacitated or in the event of later uncertainty as to whether I am dead or alive. If I have also executed a durable financial power of attorney, this document is not meant to override that document. My health care agent's powers only extend to health care decisions as outlined in this document.



(Note: This page is **not** to be attached to your Health Care Directive.)

## **INSTRUCTIONS REGARDING EXECUTION OF YOUR HEALTH CARE DIRECTIVE AND MEDICAL POWER OF ATTORNEY**

- A. Please remember to fill in your social security number below your name on the signature page.
- B. **Please note that the principal's signature is required on pages 3 and 5 of this document.**
- C. We recommend that you execute two originals of your Health Care Directive. Give the first original to the Health Care Agent you named and you retain the second original in your home in place known to family members. If you currently under medical care for a serious medical condition, we also suggest you execute a third original and give it to your primary physician.
- D. **Witnesses.** We have written this health care directive to be valid in all 49 states (and the District of Columbia) whose laws allow for this type of document. There are varying rules among the states regarding what types of persons cannot witness a health care directive. As such, we have included with our form all the prohibitions against witness from the across the country making the list somewhat length. The following persons cannot act as a witness to a health care directive:
1. A health care provider for Declarant,
  2. An employee of a health care provider for Declarant,
  3. The operator or employee of a community or long-term care facility,
  4. Patient in a health care facility in which declarant is a patient,
  5. Individual with a claim against Declarant's estate,
  6. Individual who has a financial responsibility for Declarant's medical care, and
  7. Individual related by blood, marriage, or adoption to Declarant.
- Also, the health care agent should not be one of the witnesses to this document.** The two witnesses need to be physically present when you sign the health care directive and attest to the fact that they saw you sign the document. If you have the document notarized, the witnesses will need to be with you in front of the notary.
- E. **If you are a resident of Alabama**, there are two selections in this form found on the top of page 2 that you must initial. Please read them carefully and make your selections. Also, at the bottom of page 2, there is a third blank wherein you may designate individuals to be consulted about your health care decisions besides the health care proxy. Also, please note that your health care proxy must sign this document.
- F. Where do I get a notary? Your local bank is the best place to find a notary. If you cannot find a notary at your bank, please consult your local Yellow Pages which has them listed under "notaries public".
- G. Notice: This form is not intended for use in the State of Wisconsin.
- H. What if I decide to make changes to my document? We will keep your responses to the online questionnaire in our database **for 60 days after the date of purchase**. During this time, you may go to the User Administration section of our site to call up your form questionnaire and make changes—the URL is <https://www.medlawplus.com/user/> . You shall need your "user name" and "password" to re-enter the system. Once in the User Administration area, click on the text link to your form questionnaire which is located on the upper-left of the page. Make the desired changes to your responses in the questionnaire and submit to create a revised document. If you have problems calling up your old data, email us at [administrator@medlawplus.com](mailto:administrator@medlawplus.com). We do our best to give a prompt response to all inquiries, usually within a few hours. NOTE: Upon registration, our system emailed to you our record of your "user name" and "password".

### **DISCLAIMER**

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