



Triage Health Estate Planning Toolkit: Connecticut

Part II: Understanding Estate Planning Documents in Your State

State Laws About Wills

A will is a legal document that provides instructions for what you would like to have happen to your property upon death. A will is also a place where parents can name a guardian for any minor children or adult children with developmental disabilities.

Connecticut probate courts accept written wills. To make a valid written will in Connecticut:

1. You need to be in the right state of mind to create a will. This means you need to be:
 - At least 18 years old
 - Of “sound mind” (meaning you know what you’re doing)
2. You need to sign the will or authorize someone to do so for you, in front of two witnesses who are not included in your will.
3. Your will does not need to be notarized to be legal in Connecticut, but you might want to make your will “self-proving,” or accepted in probate court without the court needing to contact your witnesses. To do this, you and your witnesses will sign an affidavit affirming the will in front of a notary.

State Laws About Financial Powers of Attorney

A power of attorney for financial affairs is a legal document where you (the principal) name a trusted adult (the agent) who is authorized to make financial decisions on your behalf.

Connecticut’s statutory form for power of attorney allows you to appoint someone to manage your finances, including assets like your property, taxes, and government benefits. You can also appoint an alternate agent, who can act jointly with the first person you appoint, or separately if the first person cannot act. This person can make all financial decisions for you, or you can limit their powers to specific areas, like filing taxes or banking. Unless you indicate otherwise in the “special instructions” section, this document takes effect immediately after you sign it, and will remain in effect if you become incapacitated. This document will remain in effect until you die, unless you specify a specific date to terminate, or revoke your power of attorney.

Part III of this toolkit includes a sample form.

State Laws About Advance Health Care Directives

An advance health care directive (AHCD) is a legal document you can use to provide written instructions, or state preferences, about your medical care in case you become unable to communicate. In Connecticut, this document includes six parts:

1. **Living Will:** You can use a living will to express your wishes for your medical care in the event you become seriously ill or unconscious. You can also provide instructions for specific situations, including administering or withholding cardiopulmonary resuscitation, artificial respiration, artificially administered nutrition (food

offered through surgically-placed tubes), comfort or pain management therapy, and any other instructions you would like to include. If you are pregnant or may become pregnant, you can indicate if you would like life-sustaining treatment to be given if it is possible the fetus/embryo would develop to birth via this treatment.

2. **Appointment of a Health Care Representative:** Here you can appoint someone (a proxy) to make health care decisions for you if your doctor determines you can no longer make these decisions yourself. You can also choose an alternate person if the first person you appoint is not available.
3. **Designation of Conservator:** This form lets you choose someone as your conservator in the event a court decides one should be appointed for you. You can also appoint an alternate (your second choice) and successor (your third choice) conservator, in case the first person you choose is not available.
4. **Organ Donation:** This section lets you indicate if you would like to make an organ or tissue donation at the time of your death.
5. **Parts V and VI:** The last two documents in your AHCD are your signature, witnesses' signatures, and a witness affidavit, which can help avoid issues in case your AHCD is challenged in court.

To make your advance health care directive valid, you must sign and date the document, or ask someone to do so for you. Your signature must be witnessed by a notary public or two witnesses. Your witnesses must be at least 18 years old, and may not be:

- Your agent
- Your health care provider or an employee of your provider

If you are executing your advance health care directive while a resident of a facility operated or licensed by the Department of Mental Health and Addiction Services or Department of Developmental Services, one witness must not be affiliated with the facility, and at least one witness must be a health care worker with specialized training in treating mental illness or developmental disabilities, depending on your circumstance.

You can revoke your AHCD at any time and in any way. To change your health care representative, indicate you want to do so in a written statement signed by two witnesses.

If you are or become pregnant, your AHCD will not be honored.

State Laws About POLST/MOLST

A medical order for life-sustaining treatment (MOLST) is a medical order completed by a seriously ill person and signed by a physician. The MOLST does not replace an advance health care directive. You can complete a MOLST form with your doctor. In Connecticut, this form lets you indicate your preferences for:

- Cardiopulmonary resuscitation orders (also known as a "Do not resuscitate," or DNR order)
- Medical Interventions, ranging from all medical and surgical treatments available to prolong your life, selective treatments to restore your health while avoiding burdensome procedures, or comfort-focused treatments to manage symptoms and allow natural death
- Medically assisted nutrition, or food offered through surgically-placed tubes
- Additional orders or instructions for your care

This form will not expire, so it is important for you and your physician to review it regularly to make sure it still reflects your wishes.

Part III includes a sample form.

State Laws About Funeral Designation Forms

Funeral designation forms allow you to tell your loved ones what you would like to happen to your remains after you pass away. These forms can be used to choose someone to control what happens to your remains after your death, specify what you would like to have happen, and other wishes depending on your state.

Connecticut does not have a funeral designation form. However, you can write down your wishes, sign the document, and have two witnesses sign. Within this document, you can indicate what you wish to happen to your body as well as designate an individual to have custody and control of your body and act as an agent to perform your wishes.

State Laws About Death with Dignity

“Death with Dignity” laws, or physician-assisted dying/aid-in-dying laws, allow certain terminally ill people to voluntarily and legally request and receive a prescription medication from their physician to hasten their death in a peaceful, humane, and dignified way. By adding a voluntary option to the continuum of end-of-life care, these laws can give you dignity, control, and peace of mind during your final days with family and loved ones.

Connecticut does not have an aid-in-dying law. But, you can indicate other preferences for end-of-life care through an advanced health care directive or MOLST.

Federal Law About HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that protects the privacy of your health information. HIPAA does allow your protected health information to be shared with your personal representative who has authority to make health care decisions for you (i.e., your health care agent or proxy).

To guarantee your agent’s access to information, a HIPAA authorization form should be signed and dated by you. Also, it must identify the information to be disclosed, the purpose of the disclosure, the recipients of the information, and an expiration date. This means that any advance health care directives should be clear about the scope of your agent’s authority to receive protected health care information.

You can revoke a HIPAA authorization form at any time by notifying your health care provider in writing.

Part III of this toolkit includes a sample HIPAA authorization form. For more information:

www.cdc.gov/php/publications/topic/hipaa.html.



Triage Health Estate Planning Toolkit: Connecticut

Part III: Your State's Estate Planning Forms

- Power of Attorney for Financial Affairs
- Advanced Health Care Directive
- Medical Order for Life-Sustaining Treatment (MOLST)
- HIPAA Authorization Form



Triage Health Estate Planning Toolkit



Part III: Your State's Estate Planning Forms



Power of Attorney for Financial Affairs

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DURABLE STATUTORY POWER OF ATTORNEY--SHORT FORM

Notice: The powers granted by this document are broad and sweeping. They are defined in the Connecticut Uniform Power of Attorney Act, which expressly permits the use of any other or different form of power of attorney desired by the parties concerned. The grantor of any power of attorney or the agent may make application to a Probate Court for an accounting as provided in subsection (d) of section 45a-175 of the general statutes. This power of attorney does not authorize the agent to make health care decisions for you.

Know All Persons by These Presents, which are intended to constitute a **GENERAL POWER OF ATTORNEY** pursuant to the Connecticut Uniform Power of Attorney Act:

That I,

(insert name and address of the principal) do hereby appoint

(insert name and address of the agent, or each agent, if more than one is designated) my agent(s) TO ACT _____.

If more than one agent is designated and the principal wishes each agent alone to be able to exercise the power conferred, insert in this blank the word 'severally'. Failure to make any insertion or the insertion of the word 'jointly' shall require the agents to act jointly.

First: In my name, place and stead in any way which I myself could do, if I were personally present, with respect to the following matters as each of them is defined in the Connecticut Uniform Power of Attorney Act to the extent that I am permitted by law to act through an agent:

(Strike out and initial in the opposite box any one or more of the subparagraphs as to which the principal does NOT desire to give the agent authority. Such elimination of any one or more of subparagraphs (A) to (M), inclusive, shall automatically constitute an elimination also of subparagraph (N).)

To strike out any subparagraph the principal must draw a line through the text of that subparagraph AND write his initials in the box opposite.

- | | |
|---------------------------------|---------|
| (A) Real property; | () |
| (B) Tangible personal property; | () |
| (C) Stocks and bonds; | () |
| (D) Commodities and options; | () |

DURABLE STATUTORY POWER OF ATTORNEY--SHORT FORM

- | | |
|--|-----|
| (E) Banks and other financial institutions; | () |
| (F) Operation of entity or business; | () |
| (G) Insurance and annuities; | () |
| (H) Estates, trusts and other beneficial interests; | () |
| (I) Claims and litigation; | () |
| (J) Personal and family maintenance; | () |
| (K) Benefits from governmental programs or civil
or military service; | () |
| (L) Retirement plans; | () |
| (M) Taxes; | () |
| (N) All other matters; | () |

(Special provisions and limitations may be included in the statutory form power of attorney only if they conform to the requirements of the Connecticut Uniform Power of Attorney Act.)

Second: LIMITATION ON AGENT'S AUTHORITY An agent MAY NOT use my property to benefit the agent or a dependent of the agent unless I have included that authority in any special instructions below.

Third: Hereby ratifying and confirming all that said agent(s) or substitute(s) do or cause to be done.

Fourth: With full and unqualified authority to exercise or delegate any or all of the foregoing powers granted under this power of attorney to any person or persons whom my agent(s) shall select.

Fifth: DESIGNATION OF SUCCESSOR AGENT(S) (OPTIONAL)

If my agent is unable or unwilling to act for me, I name as my successor agent:

Name of Successor Agent: _____

Successor Agent's Address: _____

If my successor agent is unable or unwilling to act for me, I name as my second successor agent:

DURABLE STATUTORY POWER OF ATTORNEY--SHORT FORM

Name of Second Successor Agent: _____

Second Successor Agent's Address: _____

Sixth: DESIGNATION OF CONSERVATOR OF ESTATE (OPTIONAL)

If a conservator of my estate should be appointed, I designate that _____ be appointed to serve as conservator of my estate. If _____ is unable to serve or cease to serve as conservator of my estate, I designate that _____ be appointed to serve as conservator of my estate. I direct that bond for the conservator of my estate, including any sureties thereon (be required or not be required.)

Seventh: EFFECTIVE DATE: This power of attorney is effective immediately unless I have stated otherwise in the special instructions. The execution of this statutory short form power of attorney shall be duly acknowledged by the principal in the manner prescribed for the acknowledgment of a conveyance of real property.

IN WITNESS WHEREOF, I have hereunto signed my name and affixed my seal this ____ day of _____, 20____.

(Signature of Principal) (Seal)

Print Below

Witness Sign on line

Print Below

Witness Sign on line

STATE OF CONNECTICUT

COUNTY OF _____ } ss: _____

On this the ____ day of _____, 20____, before me, (name of the principal), signer of the foregoing instrument, personally appeared, and acknowledged the execution of such instrument to be his/her free act and deed.

Commissioner of the Superior Court/Notary Public

My commission expires:



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Part III: Your State's Estate Planning Forms



Advance Health Care Directive

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ADVANCE DIRECTIVES OF _____

To Any Physician Who Is Treating Me, this document contains the following:

1. My Appointment of A Health Care Representative
2. My Living Will or Health Care Instructions
3. My Document of Anatomical Gift
4. The Designation of My Conservator Of The Person For My Future Incapacity

As my physician, you may rely on these health care instructions and decisions made by my health care representative or conservator of my person, if I am unable to make a decision for myself.

I choose not to appoint a health care representative, please go to the next page. _____ (Initial here)

APPOINTMENT OF HEALTH CARE REPRESENTATIVE

I appoint _____ to be my health care representative. If my attending physician 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 make any and all health care decisions for me, including the decision to accept or refuse any treatment, service or procedure used to diagnose or treat my physical or mental condition and the decision to provide, withhold or withdraw life support systems,** except as otherwise provided by law which excludes for example psychosurgery or shock therapy.

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.

If _____ is unwilling or unable to serve as my health care representative, I appoint _____ to be my alternative health care representative.

I further instruct that as required by law my attending physician disclose to my health care representative protected health information regarding my ability to understand and appreciate the nature and consequences of health care decisions and to reach and communicate an informed decision regarding treatment at the representative's request made at anytime after I sign this form.

I choose not to provide Health Care Instructions, please go to the next page. _____ (Initial here)

LIVING WILL or HEALTH CARE INSTRUCTIONS

If the time comes when 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 as to my own medical care, I wish this statement to stand as a statement of my wishes.

I, _____, 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, 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.

Specific Instructions

Listed below are my instructions regarding particular types of life support systems. This list is not all-inclusive. My general statement that I not be kept alive through life support systems provided to me is limited only where I have indicated that I desire a particular treatment to be provided.

	<u>Provide</u>	<u>Withhold</u>
Cardiopulmonary Resuscitation	_____	_____
Artificial Respiration (including a respirator)	_____	_____
Artificial means of providing nutrition and hydration	_____	_____
_____	_____	_____
_____	_____	_____

Other specific requests: _____

I do want sufficient pain medication to maintain my physical comfort. I do not intend any direct taking of my life, but only that my dying not be unreasonably prolonged.

DOCUMENT OF ANATOMICAL GIFT

I make no anatomical gift at this time. _____ (Initial here)

I hereby make this anatomical gift, if medically acceptable, _____ (Initial here)
to take effect upon my death

I give: (check one) _____ (1) any needed organs or parts
_____ (2) only the following organs or parts:

to be donated for: (check one)

____ (1) any of the purposes stated in subsection (a) of section 19a-279f of the general statutes

____ (2) these limited purposes _____.

DESIGNATION OF A CONSERVATOR OF THE PERSON

I choose not to designate a person to be appointed as my conservator. _____ (Initial here)

If a conservator of my person should need to be appointed, I designate _____, be appointed my conservator.

If this person is unwilling or unable to serve as my conservator of my person, I designate _____ be appointed my conservator.

No bond shall be required of either of them in any jurisdiction.

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.

X _____ L.S. Date _____, 20____

WITNESSES' STATEMENTS

This document was signed in our presence by _____ 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 this 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.

X _____
(Witness)

X _____
(Witness)

X _____
(Number and Street)

X _____
(Number and Street)

X _____
(City, State and Zip Code)

X _____
(City, State and Zip Code)

OPTIONAL FORM

WITNESSES' AFFIDAVITS

STATE OF CONNECTICUT)
)
 :ss. _____
) (Town)
COUNTY OF _____)

We, the subscribing witnesses, being duly sworn, say that we witnessed the execution of these health care instructions, the appointment 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 _____, 20____.

x _____
(Witness)
x _____
(Number and Street)
x _____
(City, State and Zip Code)

x _____
(Witness)
x _____
(Number and Street)
x _____
(City, State and Zip Code)

Subscribed and sworn to before me by _____ and _____,
the signing witnesses to the foregoing affidavit this _____ day of _____, 20____.

Commissioner of the Superior Court
Notary Public
My Commission expires: _____

(Print or type name of all persons signing under all signatures)



Triage Health Estate Planning Toolkit



Part III: Your State's Estate Planning Forms



Physician Orders for Life Sustaining Treatment (POLST)

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Patient Guide to Medical Orders for Life Sustaining Treatment (MOLST)



Connecticut Department of Public Health, 410 Capitol Avenue, P.O. Box 340308, Hartford, CT 06134

What is MOLST?

MOLST (Medical Orders for Life-Sustaining Treatment), is a process and medical order that gives you more control over your end of life care. It specifies the types of treatments that you wish to receive or not receive toward the end of your life. Completing a MOLST form encourages communication between you and your health care practitioner and that enables you to make more informed decisions. The MOLST form documents those decisions in a clear manner that can quickly be understood by all providers, including first responders and emergency services personnel. As a result your wishes can be honored across all settings of care. The MOLST program is being pilot tested under the direction of the CT Department of Public Health for one year. These guidelines pertain to this Pilot Program. You have been asked if you would like to be a Pilot Program participant.

What information about my wishes for medical treatment is on the MOLST form?

- Whether or not to attempt cardiopulmonary resuscitation
- Whether you want to be or not be hospitalized and under what conditions
- Whether you want-full, limited or comfort treatment

When would I need a MOLST form?

- The decision to create a MOLST should be discussed with your health care provider.
- The MOLST form is only intended for a person who is approaching the end stage of a serious life limiting illness such as terminal cancer or is in a condition of advanced chronic progressive frailty.

Does the law require that I complete a MOLST?

No. MOLST is voluntary.

Why is the MOLST form lime green?

The MOLST form is completed on a distinctive bright lime-green form. The bright color is to make the form quickly visible to families and emergency medical services personnel.

In what setting is the MOLST form used?

The completed, signed MOLST form is a medical order that will remain with you if you are transported between care settings, regardless of whether you are in the hospital, at home or in a long-term care facility. The MOLST form is designed to be used to convey your medical orders to healthcare providers including paramedics who arrive after 9-1-1 has been called.

Does the MOLST form travel with me between settings of care?

Yes, the MOLST form is designed to be a standard form that may be accepted by participating pilot program providers. As a legal medical order, it can be honored by EMS, hospitals, long term care facilities and home care hospice providers and included in your medical records.

Does the MOLST form need to be signed?

Yes. You, or if you are incapacitated, your Legally Authorized Representative (LAR) and your Medical Doctor/Doctor of Osteopathy (MD/DO) Advanced Practice Registered Nurse (APRN) or Physician Assistant (PA) must sign the form in order for it to be a “Provider Order” that is understood and followed by other health care providers, including EMS personnel. During the pilot program, the form must also be signed by a witness.

What is a Legally Authorized Representative (LAR)?

A Legally Authorized Representative is someone who is legally authorized to decide whether you will participate in the MOLST pilot program. The LAR can legally sign a MOLST for you when you are not able to make decisions for yourself.

- A legally authorized representative can be your parent, guardian or health care representative.
- A health care representative is a person appointed in writing under CT General Statutes §§19a-576 and 19a-577 to make any and all health care decisions on a person’s behalf when the person is unable to communicate his or her decisions about medical care.

What if I am no longer able to communicate my wishes and I do not have a MOLST?

Your MD/DO, APRN or PA can complete the MOLST form with your (LAR) based on his or her understanding of your wishes.

I have a DNR Bracelet. Will it still be honored by Emergency Medical Services (EMS)?

Yes, the DNR Bracelet is still a valid method to communicate a person’s wishes to forgo cardio-pulmonary resuscitation.

If I have a MOLST Form do I still need a living will or similar advance health care directive (AHCD)?

It is recommended that everyone have a living will or similar AHCD and appoint a health care representative (HCR). The MOLST form complements the AHCD and documents the decisions made following a conversation between you and your health care provider about the preferences for the type of medical care that you want or do not want and under what conditions.

Where is the MOLST form kept?

Your MOLST Form is your personal property. If you live at home, you should keep the original lime green MOLST form in a location where it can easily be seen. The ideal place is on your refrigerator where EMS personnel will look for it first. If you reside in a long-term care facility or other type of facility, your MOLST form may be kept in your medical chart along with other medical orders.

Where can I get a MOLST form?

Participating hospitals, nursing homes, home health and hospice providers in the pilot program have blank original forms. Talk to your health care provider who can help you in understanding and completing the form. Remember, the MOLST form must be signed by you and your MD/DO, APRN or PA) and a witness to be valid. If you want additional copies of your MOLST form request them from your provider.

For the latest information about MOLST please visit: www.ct.gov/dph

Section C (Check one box only)

Medically Administered Hydration (oral or by mouth hydration will always be offered if feasible)

<input type="checkbox"/> Use medically administered hydration	<input type="checkbox"/> No medically administered hydration	<input type="checkbox"/> Undecided
<input type="checkbox"/> Use medically administered hydration, defined trial period Length of trial period: _____		<input type="checkbox"/> Did not discuss

Medically Administered Nutrition (oral or by mouth nutrition will always be offered if feasible)

<input type="checkbox"/> Use medically administered nutrition, such as total parenteral nutrition or tube feedings	<input type="checkbox"/> No medically administered nutrition	<input type="checkbox"/> Undecided
<input type="checkbox"/> Use medically administered nutrition defined trial period Length of trial period: _____		<input type="checkbox"/> Did not discuss

Dialysis

<input type="checkbox"/> Use dialysis	<input type="checkbox"/> No dialysis	<input type="checkbox"/> Undecided
<input type="checkbox"/> Use dialysis, defined trial period Length of trial period: _____		<input type="checkbox"/> Did not discuss

Other treatment preferences specific to the patient's medical condition, e.g. vasopressors, medications, antibiotics, etc.

Section D

For this form to be valid: The form must be a lime green original MOLST form and the provider signing must ensure the form is thoroughly completed and signed by the patient or patient's legally authorized representative, provider and witness. A form that is incomplete, improperly completed or amended, except as permitted in Section E shall be deemed invalid and of no effect.

Discussed with:

Patient

Legally Authorized Representative (specify) _____

Signature below confirms this form was signed by the patient or Legally Authorized Representative **voluntarily** and reflects his/her wishes and goals of treatment as expressed to the provider signing below. Signature by a patient representative as indicated above confirms the form reflects his/her assessment of the patient's preferences or goals of care, or if those preferences are unknown, his/her understanding of the patient's best interests.

Signature of Patient or Legally Authorized Representative:	Date:
Printed Name of Patient or Legally Authorized Representative:	
Signature of Provider: _____	<input type="checkbox"/> MD/DO <input type="checkbox"/> APRN <input type="checkbox"/> PA
Printed Name of Provider:	Date:
Provider Phone Number:	
Signature of Witness:	
Printed Name of Witness:	Date:
Interpreter Name or ID# and/or Service	Date:

Section E
Review of this MOLST form

Date of Review	Provider Signature	Printed Name	Credentials	Reviewed With	Location of Review	Outcome of Review
			<input type="checkbox"/> MD/DO <input type="checkbox"/> APRN <input type="checkbox"/> PA			<input type="checkbox"/> No Change <input type="checkbox"/> FORM VOIDED new form completed <input type="checkbox"/> FORM VOIDED no new form
			<input type="checkbox"/> MD/DO <input type="checkbox"/> APRN <input type="checkbox"/> PA			<input type="checkbox"/> No Change <input type="checkbox"/> FORM VOIDED new form completed <input type="checkbox"/> FORM VOIDED no new form
			<input type="checkbox"/> MD/DO <input type="checkbox"/> APRN <input type="checkbox"/> PA			<input type="checkbox"/> No Change <input type="checkbox"/> FORM VOIDED new form completed <input type="checkbox"/> FORM VOIDED no new form
			<input type="checkbox"/> MD/DO <input type="checkbox"/> APRN <input type="checkbox"/> PA			<input type="checkbox"/> No Change <input type="checkbox"/> FORM VOIDED new form completed <input type="checkbox"/> FORM VOIDED no new form
			<input type="checkbox"/> MD/DO <input type="checkbox"/> APRN <input type="checkbox"/> PA			<input type="checkbox"/> No Change <input type="checkbox"/> FORM VOIDED new form completed <input type="checkbox"/> FORM VOIDED no new form

Review of MOLST Form

This form should be reviewed upon transfer of a patient to a hospital or other health care facility, or if there is a substantial change in the patient's health status or treatment preferences. Any change to this form requires the form to be voided and a new form to be signed. To void the form, write VOID in large letters on the front of the form. If no new form is completed, no limitations on treatment are documented and full treatment may be provided.

Additional Instructions For Health Care Professionals

THIS FORM IS VOLUNTARY FOR THE PATIENT

Follow orders listed in section A, B and C until there is an opportunity for the clinician to review the form with the patient or the legally authorized representative (when the patient lacks capacity).

The patient or legally authorized representative (if the patient lacks capacity) can revoke the MOLST form at any time and/or request and receive previously refused medically-indicated treatment .

If the patient or legally authorized representative elects short term use of a medical intervention then the trial period **MUST** be filled in on the form.



Triage Health Estate Planning Toolkit



Part III: Your State's Estate Planning Forms



HIPAA Authorization Form

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Sample HIPAA Right of Access Form for Family Member/Friend

I, _____, direct my health care and medical services providers and payers to disclose and release my protected health information described below to:

Name:

Relationship:

Contact information: _____

Health Information to be disclosed upon the request of the person named above --
(Check either A or B):

- A. **Disclose** my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) **OR**
- B. **Disclose** my health record, as above, **BUT do not disclose** the following (check as appropriate):
 - Mental health records
 - Communicable diseases (including HIV and AIDS)
 - Alcohol/drug abuse treatment
 - Other (please specify):

Form of Disclosure (unless another format is mutually agreed upon between my provider and designee):

- An electronic record or access through an online portal
- Hard copy

This authorization shall be effective until (Check one):

- All past, present, and future periods, OR
- Date or event: _____

unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

Name of the Individual Giving this Authorization

Date of birth

Signature of the Individual Giving this Authorization

Date

Note: HIPAA Authority for Right of Access: 45 C.F.R. § 164.524