Triage Health Estate Planning Toolkit: Montana

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.

Montana probate courts accept written and holographic wills. To make a valid written will in Montana:

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, in front of two witnesses.
3. Your will does not need to be notarized to be legal in Montana. However, you can 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 must sign an affidavit affirming the will in front of a notary.

Montana allows you to execute your will remotely (e.g. witness the signing of a will by teleconferencing). However, before you execute your will remotely, you should check your state's laws to make sure that this is still allowed at the time you are executing your will.

A holographic will is one that is handwritten by you. To make a valid holographic will in Montana:

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, or an emancipated minor
    - Of "sound mind" (meaning you know what you're doing)
2. Your will must be written in your handwriting and you must sign it.

If you make a holographic will, it does not need to be signed by witnesses. However, most estate planning experts do not recommend relying on holographic wills because it is more difficult to prove that they are valid in probate court.

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.

In Montana, a power of attorney allows you to appoint someone to manage your finances, including your property, taxes, and government benefits. Unless you indicate otherwise in the "special instructions" section, this will take effect immediately after you sign it. You can also appoint a co-agent in this section, or a second person to help oversee your finances. This document will remain in effect until you die, unless you revoke your power of attorney.

Part III 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. The Montana My Choices AdvanceDirective includes five parts.

1. **Terminal Conditions (Living Will).** This document lets you indicate your preferences for health care if you become unable to speak for yourself and are permanently unconscious or terminally ill. This includes instructions for life-prolonging procedures, artificial nutrition and hydration, and relief from pain.

2. **Chronic Illness or Serious Disability (Optional).** This section allows you to describe any chronic illness or serious disability that you have that should not be misinterpreted as a terminal condition. It also allows you to give special directions regarding your condition as well as the contact information for your treating physician.

3. **Power of Attorney for Health Care (Health Care Representative).** You can use this section to appoint someone (an agent) to make decisions about your medical care for you, any time you become unable to make health care decisions or communicate for yourself. You can also choose an alternate representative if the first person you appoint is not available.

4. **Signature and Witnessing Provisions:** You must sign your AHCD in front of two qualified witnesses. Your witnesses must be at least 18 years old, know you personally, and believe you understand the decisions you are making in this directive. If possible, it's recommended that you sign in front of a notary.

5. **Special Directions.** This section allows you to provide guidance on spiritual preferences, where you would like to be when you die, organ donation, after-death care (meaning disposition of remains and funeral preferences), and additional directions you may have.

If you are pregnant and the decisions you make in this document would interfere with facilitating life-sustaining treatment to the fetus, then it will not be honored.

You can indicate that you would like to change any other instruction included in your AHCD at any time. You can simply tell your physician you would like to revoke or change your AHCD, do so in writing, or just tear up this directive. But, you have to tell your agent, physician, or treating health care provider that you revoked your agent's powers for it to be effective.

If you appoint your spouse as your agent, this will be automatically revoked if your marriage dissolves.

Part III of this toolkit includes a sample form.

State Laws About POLST/MOLST

A physician order for life-sustaining treatment (POLST) is a medical order completed by a seriously ill person and signed by a physician. The POLST does not replace an advance directive. You can complete a POLST form with your doctor. In Montana, this form is called Provider Orders for Life-Sustaining Treatment, and it 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 and hydration offered through surgically-placed tubes

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.

You can find this form in Part III of this toolkit.

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.

Montana's funeral designation is within Part 5 of the advance health care directive. Part III of this toolkit includes a sample form.

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.

While Montana does not have a death with dignity law, a State Supreme Court ruling makes physician-assisted dying legal. In the 2009 *Baxter v. Montana* ruling, the court decided that nothing in state law prevented physicians from honoring a terminally ill, mentally competent (meaning they can make decisions for themselves) patient's request for medication to hasten their death.

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/phlp/publications/topic/hipaa.html.

Triage Health Estate Planning Toolkit: Montana

Part III: Your State's Estate Planning Forms

- Power of Attorney for Financial Affairs
- Advanced Health Care Directive
- Provider Orders for Life-Sustaining Treatment (POLST)
- HIPAA Authorization Form

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Part III: Your State's Estate Planning Forms

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Power of Attorney for Financial Affairs

Montana Statutory Form Power of Attorney
Important Information for Principal

This power of attorney authorizes another person (your agent) to make decisions concerning your property for you (the principal). Your agent will be able to make decisions and act with respect to your property (including your money) whether or not you are able to act for yourself. The meaning of authority over subjects listed on this form is explained in the Montana Codes Annotated, Uniform Power of Attorney Act, Title 72, chapter 31, part 3.

This power of attorney **does not** authorize the agent to make **health care decisions** for you.

You should select someone you trust to serve as your agent. Unless you specify otherwise, generally the agent's authority will continue until you die or revoke the power of attorney or the agent resigns or is unable to act for you.

Your agent is entitled to reasonable compensation unless you state otherwise in the Special Instructions.

This form provides for designation of one agent. If you wish to name more than one agent, you may name a coagent in the Special Instructions. Coagents are not required to act together unless you include that requirement in the Special Instructions.

If your agent is unable or unwilling to act for you, your power of attorney will end unless you have named a successor agent. You may also name a second successor agent.

This power of attorney becomes effective immediately unless you state otherwise in the Special Instructions.

If you have questions about the power of attorney or the authority you are granting to your agent, you should seek legal advice before signing this form.

DESIGNATION OF AGENT

I _____
(Name of Principal)

name the following person as my agent:

Name of Agent: _____
Agent's Address: _____
Agent's Telephone Number: _____

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: _____
Successor Agent's Telephone Number: _____

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

Name of Second Successor Agent: _____
Second Successor Agent's Address: _____
Second Successor Agent's Telephone Number: _____

GRANT OF GENERAL AUTHORITY

I grant my agent and any successor agent general authority to act for me with respect to the following subjects as defined in the Uniform Power of Attorney Act, Title 72, chapter 31, part 3:

INITIAL each subject you want to include in the agent's general authority. If you wish to grant general authority over all of the subjects you may initial "All Preceding Subjects" instead of initialing each subject.

(_____) Real Property
(_____) Tangible Personal Property
(_____) Stocks and Bonds
(_____) Commodities and Options
(_____) Banks and Other Financial Institutions
(_____) Operation of Entity or Business
(_____) Insurance and Annuities
(_____) Estates, Trusts, and Other Beneficial Interests
(_____) Claims and Litigation
(_____) Personal and Family Maintenance
(_____) Benefits from Governmental Programs or Civil or Military Service
(_____) Retirement Plans
(_____) Taxes
(_____) All Preceding Subjects

LIMITATION ON AGENT'S AUTHORITY

An agent that is not my ancestor, spouse, or descendant MAY NOT use my property to benefit the agent or a person to whom the agent owes an obligation of support unless I have included that authority in the Special Instructions.

SPECIAL INSTRUCTIONS (OPTIONAL)

You may give special instructions on the following lines:

_____

_____

_____

_____

EFFECTIVE DATE

This power of attorney is effective immediately unless I have stated otherwise in the Special Instructions.

NOMINATION OF CONSERVATOR OR GUARDIAN (OPTIONAL)

If it becomes necessary for a court to appoint a conservator or guardian of my estate or guardian of my person, I nominate the following person(s) for appointment:

Name of Nominee for conservator or guardian of my estate: _____
Nominee's Address: _____
Nominee's Telephone Number: _____
Name of Nominee for guardian of my person: _____
Nominee's Address: _____
Nominee's Telephone Number: _____

RELIANCE ON THIS POWER OF ATTORNEY

Any person, including my agent, may rely upon the validity of this power of attorney or a copy of it unless that person knows it has terminated or is invalid.

SIGNATURE AND ACKNOWLEDGMENT

_____ _____

Your Signature Date

_____

Your Name Printed

_____

Your Address

_____

Your Telephone Number

State of Montana
County of _____

This document was acknowledged before me on _____

by _____.
Print name of signer(s)

_____

Notary Signature

[Montana notaries must complete the following, if not part of stamp.]

_____

Printed Name

Notary Public for the State of Montana

Affix seal/stamp as close to signature as possible.

Residing at _____

My Commission expires:_____,20_____

Montana Statutory Form Power of Attorney

IMPORTANT INFORMATION FOR AGENT

Agent's Duties

When you accept the authority granted under this power of attorney, a special legal relationship is created between you and the principal. This relationship imposes upon you legal duties that continue until you resign or the power of attorney is terminated or revoked. You must:

(1) do what you know the principal reasonably expects you to do with the principal's property or, if you do not know the principal's expectations, act in the principal's best interest;
(2) act in good faith;
(3) do nothing beyond the authority granted in this power of attorney; and
(4) disclose your identity as an agent whenever you act for the principal by writing or printing the name of the principal and signing your own name as "agent" in the following manner: (Principal's Name) by (Your Signature) as Agent

Unless the Special Instructions in this power of attorney state otherwise, you must also:

(1) act loyally for the principal's benefit;
(2) avoid conflicts that would impair your ability to act in the principal's best interest;
(3) act with care, competence, and diligence;
(4) keep a record of all receipts, disbursements, and transactions made on behalf of the principal;
(5) cooperate with any person that has authority to make health care decisions for the principal to do what you know the principal reasonably expects or, if you do not know the principal's expectations, to act in the principal's best interest; and
(6) attempt to preserve the principal's estate plan if you know the plan and preserving the plan is consistent with the principal's best interest.

TERMINATION OF AGENT'S AUTHORITY

You must stop acting on behalf of the principal if you learn of any event that terminates this power of attorney or your authority under this power of attorney. Events that terminate a power of attorney or your authority to act under a power of attorney include:

(1) death of the principal;
(2) the principal's revocation of the power of attorney or your authority;
(3) the occurrence of a termination event stated in the power of attorney;
(4) the purpose of the power of attorney is fully accomplished; or
(5) if you are married to the principal, a legal action is filed with a court to end your marriage, or for your legal separation, unless the Special Instructions in this power of attorney state that such an action will not terminate your authority.

LIABILITY OF AGENT

The meaning of the authority granted to you is defined in the Uniform Power of Attorney Act, Title 72, chapter 31, part 3. If you violate the Uniform Power of Attorney Act, Title 72, chapter 31, part 3, or act outside the authority granted, you may be liable for any damages caused by your violation.

If there is anything about this document or your duties that you do not understand, you should seek legal advice.

AGENT'S CERTIFICATION
Montana Code Annotated §72-31-353
AS TO THE VALIDITY OF POWER OF ATTORNEY AND AGENT'S AUTHORITY

State of _____
County of:_____

I_____ (Name of Agent)
certify under penalty of perjury that _____

_____ (Name of Principal) granted my authority as an agent or successor agent in a power of attorney dated _____

I further certify that to my knowledge:

(1) the principal is alive and has not revoked the power of attorney or my authority to act under the power of attorney and the power of attorney and my authority to act under the power of attorney have not terminated;
(2) if the power of attorney was drafted to become effective upon the happening of an event or contingency, the event or contingency has occurred;
(3) if I was named as a successor agent, the prior agent is no longer able or willing to serve; and
(4) _____
(Insert Other Relevant Statements)

SIGNATURE AND ACKNOWLEDGEMENT

_____ _____
Agent's Signature Date

_____
Agent's Name Printed

_____
Agent's Address

_____
Agent's Telephone Number

State of
County of _____

Signed and sworn to (or affirmed) before me on_____
(Date)

by _____.
Name of Agent

_____
Notary Signature

[Montana notaries must complete the following, if not part of stamp.]

Affix seal/stamp as close to

_____
Printed Name

Notary Public for the State of Montana

Residing at_____

My Commission expires:_____, 20_____

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Part III: Your State's Estate Planning Forms

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Advance Health Care Directive

PRINT YOUR FULL NAME HERE

Full Name: _____
Please print

1. Terminal Conditions (Living Will)

I provide these directions in accordance with the Montana Rights of the Terminally Ill Act. These are my wishes for the kind of treatment I want if I cannot communicate or make my own decisions. These directions are only valid if both of the following two conditions exist:

1. **I have a terminal condition, and**
2. **in the opinion of my attending physician, I will die in a relatively short time without life sustaining treatment that only prolongs the dying process.**

I authorize my Representative, if I have appointed one, to make the decision to provide, withhold, or withdraw any health care treatment.

General Treatment Directions

Check the boxes that express your wishes: (Check only one)

CHECK ONLY ONE BOX

☐ I provide no directions at this time.

☐ I direct my attending physician to withdraw or withhold treatment that merely prolongs the dying process.

I further direct that (check all boxes that apply):

CHECK ALL BOXES THAT APPLY

☐ Treatment be given to maintain my dignity, keep me comfortable and relieve pain.

☐ If I cannot drink, I do not want to receive fluids through a needle or catheter placed in my body unless for comfort.

☐ If I cannot eat, I do not want a tube inserted in my nose or mouth, or surgically placed in my stomach to give me food.

☐ If I have a serious infection, I do not want antibiotics to prolong my life. Antibiotics may be used to treat a painful infection.

CHECK ONLY ONE BOX

I have attached additional directives regarding medical treatment to this form:

☐ Yes ☐ No

PRINT THE DIAGNOSIS OF YOUR CHRONIC ILLNESS OR SERIOUS DISABILITY, IF ANY

PRINT THE NAME OF THE PHYSICIAN WHO TREATS YOUR CONDITION

ADD ADDITIONAL DIRECTIONS, IF ANY, REGARDING YOUR CHRONIC ILLNESS OR SERIOUS DISABILITY

2. Chronic Illness or Serious Disability (Optional)

My chronic illness or disability can complicate an acute illness, but should not be misinterpreted as a terminal condition.

Diagnosis_____

Consult my physician _____
Name Phone

Special directions (use additional pages if necessary) _____

CHECK ONLY ONE BOX

PRINT THE NAME, ADDRESS, AND PHONE NUMBERS OF YOUR PRIMARY REPRESENTATIVE

PRINT THE NAME, ADDRESS AND PHONE NUMBERS OF YOUR ALTERNATE REPRESENTATIVES

3. Health Care Representative (Power of Attorney for HealthCare)

I wish to appoint a representative ☐ Yes ☐ No

A. Primary Representative

I appoint_____as my representative.

_____
Representative's Address

_____
City State Zip

_____
Home Phone Work Phone

My Representative's authority is effective when I cannot make health care decisions or communicate my wishes. I may revoke this authority at any time I regain these abilities (unless my attending physician and any necessary experts determine I am not capable of making decisions in my own best interest).

If, for any reason, I should need a guardian of my person designated by a court, I nominate my Representative, or Alternate Representative(s), named below.

B. Alternate Representative(s)

If: 1. I revoke my representative's authority; or
2. My representative becomes unwilling or unable to act for me; or
3. My representative is my spouse and I become legally separated or divorced,

I name the following person(s) as alternates to my representative in the order listed:

1._____
Print Alternate Representative's Full Name

_____
Address

_____
City State Zip

_____
Home Phone Work Phone

2._____
Print Alternate Representative's Full Name

_____
Address

_____
City State Zip

_____
Home Phone Work Phone

PRINT THE DATE HERE

SIGN AND PRINT YOUR NAME, ADDRESS AND TELEPHONE NUMBERS HERE

YOUR WITNESSES MUST SIGN AND PRINT THE DATE AND THEIR NAMES AND ADDRESSES HERE

Part 5. Signing and Witnessing this Advance Directive

A. Your Signature

Ask two people to watch you sign and have them sign below.

1. I revoke any prior health care advance directive or directions.
2. This document is intended to be valid in any jurisdiction in which it is presented.
3. A copy of this document is intended to have the same effect as the original.
4. Those who act as I have directed in this document shall be free from legal liability for having followed my directions.
5. If my attending physician is unwilling or unable to comply with my wishes as stated in this document, I direct my care be transferred to a physician who will.

I sign this document on the_____day of_____, 20_____

_____ _____
Signature Print Full Name

_____
Address

_____
City State Zip

_____
Home Phone Work Phone

B. Ask Your Witnesses to Read and Sign

I declare that I am over the age of 18 and the person who signed this document is personally known to me, and has signed these health care advance directives in my presence, and appears to be of sound mind and under no duress, fraud or undue influence.

1. _____
Signature Date

_____
Printed Name

_____
Address

2. _____
Signature Date

_____
Printed Name

_____
Address

ALL OF THE FOLLOWING IN PART 4 ARE OPTIONAL

INDICATE YOUR RELIGIOUS OR SPIRITUAL PREFERENCE

CHECK THE BOX TO INDICATE WHERE YOU WOULD PREFER TO DIE

ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES,

SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

Part 4. Special Directions (Optional)

A. Spiritual Preferences

My religion _____

My faith community _____

Contact person _____

I would like spiritual support ☐ Yes ☐ No

B. Where I Would Like to be When I Die

☐ My home ☐ Hospital ☐ Nursing home ☐ Hospice

☐ Other _____

C. Donation of Organs at My Death (check one of the following):

☐ I do not wish to donate any of my body, organs, or tissue.

☐ I wish to donate my entire body.

☐ I wish to donate **only** the following (check all that apply):

☐ Any organs, tissues, or body parts ☐ Heart ☐ Kidneys

☐ Lungs ☐ Bone Marrow ☐ Eyes ☐ Skin ☐ Liver

☐ Other(s) _____

D. After-Death Care (care of my body, burial, cremation, funeral homepreference)

_____

E. Additional Directions (use additional pages if necessary)

Signature _____ **Date** _____

CHECK THE BOX INDICATING WHETHER YOU PLAN TO REGISTER YOUR ADVANCE DIRECTIVE

PRINT THE NAME(S), ADDRESS(ES), AND PHONE NUMBER(S) OF THE PERSON(S) YOU PLAN TO SEND COPIES OF YOUR ADVANCE DIRECTIVE

A. Distributing this Advance Directive

I plan to deposit this Advance Directive in the Montana End-of-Life Registry: Yes No

I plan to send copies of this document to the following people or locations:

Physician Name:

_____

_____

Address

_____

City State Zip

_____

Home Phone Work Phone

Family Member: Relationship _____

_____

Name

_____

Address

_____

City State Zip

_____

Home Phone Work Phone

Hospital:

_____

Name

_____

Address

_____

City State Zip

_____

Home Phone Work Phone

Clergy:

_____

Name

_____

Address

_____

City State Zip

_____

Home Phone Work Phone

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Physician Orders for Life Sustaining Treatment (POLST)

SEND ORIGINAL FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED
HIPAA PERMITS DISCLOSURE OF THIS INFORMATION TO OTHER HEALTHCARE PROFESSIONALS AS NECESSARY

Montana Provider Orders for Life-Sustaining Treatment (POLST)

- **FIRST follow these orders, THEN contact Physician, Advanced Practice Registered Nurse (APRN) or Physician Assistant (PA) for further orders if indicated.**
- These Medical Orders are based on the person's medical condition & wishes.
- If Section A or B is not completed, full treatment for that section is implied.
- Completing a POLST is **ALWAYS VOLUNTARY**.

Legal Last Name	
Legal First Name/Middle Name	
Date of Birth	

In preparing these orders, inquire if the patient has a living will or other advance directive. If yes and available, review for consistency with these orders and update as needed.

A
Check one box only

CARDIOPULMONARY RESUSCITATION (CPR) *****Person has NO pulse and is not breathing.* ****

☐ **YES CPR:** Attempt Resuscitation ☐ **NO CPR:** Do Not Attempt Resuscitation (DNAR)/ Allow Natural Death (AND)

NOTE: *Selecting 'Yes CPR' requires choosing "Full Treatment" in Section When not in cardiopulmonary arrest, follow orders in Section B.*

B
Check one box only

MEDICAL INTERVENTIONS *****Person HAS a pulse and is breathing.*** ****

☐ **Full Treatment–primary goal to prolong life by all medically effective means:**
In addition to treatments described below in "Selective Treatment" and "Comfort-focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion, as indicated. Transfer to hospital, if indicated. Includes intensive care.

☐ **Selective Treatment–goal to treat medical conditions while avoiding burdensome measures:**
In addition to treatment described below in "Comfort-focused Treatment," use IV antibiotics and IV fluids, as indicated. **Do not intubate.** May use noninvasive positive airway pressure. Transfer to hospital if indicated. **Avoid intensive care.**

☐ **Comfort-focused Treatment–primary goal to maximize comfort:**
Relieve pain and suffering with medication by any route, as needed; use oxygen, suctioning, and manual treatment of airway obstruction, if indicated. Do not use treatments listed in "Full Treatment" and "Selective Treatment" above, unless consistent with comfort goal. **Do not transfer to hospital for life-sustaining treatment. Transfer only if comfort needs cannot be met in current location.**

C
Check one box only

ARTIFICIALLY ADMINISTERED NUTRITION ** ***If feasible, always offer food & water by mouth.*** **

☐ Artificial nutrition by tube--long term/permanent, if indicated.
☐ Artificial nutrition by tube--short term/temporary only.
☐ No artificial nutrition by tube. ☐ No decision has been made

D

DISCUSSED WITH (check all that apply):
☐ Patient
☐ Medical Power of Attorney
☐ Legal guardian
☐ Other (Name & Relationship):_____

SIGNATURES OF PROVIDER AND PATIENT, Surrogate, Medical Power of Attorney, and Legal GUARDIAN (*MANDATORY*)

If signed by surrogate legal decision maker, preferences expressed must reflect patient's wishes as best understood by surrogate.
Significant thought has been given to these instructions. Preferences have been discussed and expressed to a healthcare professional. This document reflects those treatment preferences, which may also be documented in a Medical Power of Attorney, CPR order, Living Will, or other Advance Directive (attach if available).

Patient/Legal Decision Maker Signature *(Mandatory)*	***Name*** *(Print)*	***Relationship/ Decision maker status*** *(Write "self" if patient)*	***Date Signed*** *(Mandatory)*

SIGNATURE OF PROVIDER: **My signature below indicates to the best of my knowledge that these orders are consistent with the patient preferences.**

Name of Person Preparing Form	***Phone number of Preparer***	***Date Performed***

Physician / APRN / PA Signature *(Mandatory)*	***Print Physician / APRN / PA Name***	***Date Signed*** *(Mandatory)*

Directions for Health Care Professionals

Completing POLST

- Completed by a health care professional based on patient preferences and medical indications.
- Provider signature must be a Montana licensed physician, advanced practice registered nurse or physician assistant.
- Patient (or legal decision-maker, if patient unable to make medical decisions), **must sign** to be valid.
- Verbal orders are acceptable with follow-up signature by provider in accordance with organization/ community policy.
- Documentation of conversations regarding POLST completion should be in the medical record.
- Use of the original form is strongly encouraged. Photocopies and FAXs of signed POLST forms are legal and valid. The patient should retain the original on "Terra" Green colored paper.

Using POLST

- Any incomplete section of POLST implies full treatment for that section.

Section A:

- **No** defibrillator (including automated external defibrillators) should be used on a patient who has chosen "Do Not Attempt Resuscitation."

Section B:

- Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), bi- level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations.
- When comfort cannot be achieved in the current setting, the patient, including someone with "Comfort-focused Treatment," should be transferred to a setting able to provide comfort (i.e. treatment of a hip fracture).
- IV medication to enhance comfort may be appropriate for a patient who has chosen "Comfort-focused Treatment."

Section C:

- Certain medical conditions may prevent intake of food and water, as it can worsen symptoms.
- If this applies, further discussion with and documentation by a healthcare provider is required.

Reviewing POLST

- Previously completed advance directives should not conflict with these Montana Provider Orders for Life-Sustaining Treatment (POLST) unless significant discussion and documentation between the patient, legal decision maker and healthcare provider occurs and is documented.
- POLST review is recommended when:
    - The patient is transferred from one care setting or care level to another.
    - There is substantial change in the patient's health care status including previous wishes that conflict with medical recommendations.
    - The patient has a change in treatment preference.

Modifying and Voiding POLST

- At any time a patient or legal decision-maker can void the POLST form or change his/her mind about his/her treatment preferences by executing a verbal or written advance directive or completing a new POLST.
- To void POLST, draw a line through Sections A through D and write "VOID" in large letters. Sign and date.
- The most recently dated POLST is considered the valid POLST and supersede all prior POLST directives.

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HIPAA Authorization Form

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