

## DOWNLOAD COVERSHEET:

This is a standard advance directive for your state, made available to you as a courtesy by Lifecare Directives, LLC. You should be aware that extensive research has demonstrated that there are significant drawbacks to using a very brief state-standard document. As one researcher has noted, “the development of statutory forms occurs in the legislative arena, [so] their content is the result of a political rather than a ‘scientific’ process.” Because of “political compromise, ...many of the forms ultimately passed by the legislatures are not optimal from a consumer perspective” (see: Hoffmann, Diane E; Zimmerman, S; Tompkins, C. The dangers of directives, or the false security of forms. *Journal of Law, Medicine & Ethics*. 1996;24(1) (Spring):5-17).

American Bar Association concurs, noting that “The statutory advance directive is not necessarily the exclusive, or even the best, pathway for individuals to follow,” and suggesting that revised and enhanced documents “may be especially helpful as a...replacement for statutory forms where restrictions in a statutory directive prevents the individual from fully expressing his or her wishes” (see: American Bar Association. (1991). *Patient Self Determination Act State Law Guide*. Government printing office, Washington, DC).

*Lifecare Directives* staff have reviewed more than 6,000 medical, legal, academic, and news media articles on advance directives, as well as reviewing hundreds of document forms. They have also conducted formal research with scores of medical, legal, and academic professionals along with more than 1,000 lay public participants. From this process, more than 30 additional key living will and medical power of attorney enhancements have been identified that should be included in any living will (or “health care instruction” or “declaration”) and medical power of attorney (or “proxy”) forms that you may use.

Please consider obtaining the *Lifecare Advance Healthcare Directive* to obtain these important additions and benefits. To better understand the important enhancements available through this combined living will and medical power of attorney, you may wish to obtain the booklet, “*Should I Use a Shorter Standard Directive?*” available through Lifecare Directives, LLC.

If you have any other questions about this document or other Lifecare resources, please do not hesitate to contact our staff who will make every effort to fully respond your inquiries and address any questions you may have. We can be reached at the following:

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~ Lifecare Directives ~

*Statutory  
Advance Directive  
For  
Hawaii Residents*



*Statutory Compliant  
Advance Directive for  
Health Care Choices*



~ Lifecare Directives ~



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Advance Directive  
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*Statutory Compliant  
Advance Directive for  
Health Care Choices*

***Important Notice:***

An advance directive is not a substitute for medical, legal or other necessary advice or direction. This document should not be construed as offering counseling, medical, legal, financial, or estate planning or advice, nor any other similar guidance or direction. Such counsel should be obtained from qualified, certified, and licensed professionals in your locale who are experienced in the specific areas of concern. Completion of this document constitutes acceptance of its content both in whole and in part, as well as a determination of its utility for the purposes indicated. Lifecare Directives, LLC, and all involved in this document's design, publication, and distribution assume no liability for its use, including that which may arise from omissions, technical inaccuracies, and typographical errors. Diligent efforts notwithstanding, this document is not warranted to be in compliance with state and local laws. All warranties, including those of merchantability, fitness for a particular purpose, and non-infringement are expressly disclaimed. The utilizer agrees to seek appropriate outside review prior to completion. The utilizer and all heirs, assigns, designees, devisees, representatives, and all others involved, agree to assume all liability for its use and any subsequent outcomes, and to release and hold harmless all involved in its design, publication, advertising and distribution. The utilizer also agrees that any physician, health care provider, agent, proxy, surrogate, representative, mediator, court officer, and all others relying on the document's content are similarly free of all liability, when they act in good faith and with due diligence to follow the recorded wishes and directions.

# Statutory Advance Directive For Hawaii Residents

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Print Full Name

Date of Birth

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**Your right** (when age 18 or older): To Document Your Personal Wishes,  
and to have these wishes followed ~~

The Hawaii legislature has provided statutes guiding the construction of both a living will and a Power of Attorney for Health Care for use by the public. Collectively, these documents are known as “advance directives.” As the content of this directive was drawn from the Uniform Health Care Act, it is in compliance with all applicable statutes and laws.

There is an introduction to each that summarizes the scope and purpose of the documents, as well as providing further directions for completion. Read them carefully to ensure that your advance directives are fully and properly filled out.

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## ***Understanding Your Directive***

To make the *best* choices for your medical care, your physician needs to know your wishes. In fact, the law requires doctors to seek your permission before giving you *any* treatment. However, if you are ever unable to make decisions due to severe illness or injury, this may not be possible. Completing this Directive will help your family and physicians know who should speak for you, and understand what you want if you cannot make this known yourself.

You can **revoke** (cancel) this directive at **any** time by: **1)** writing “revoked” across the front of the directive, followed by your signature and date, and the signature of at least one witness aged 18 years or older ; or **2)** by completing a Notice of Revocation; or **3)** by *telling* an adult witness that you want it revoked (who must then sign and date a statement, which becomes effective only when given to your doctor or health care provider); or **4)** by *simply completing a new directive* in which you state that any prior directive is no longer valid.

You can **limit** your directive and the authority of anyone named in it, but *no changes are recommended after the document is witnessed*. Any scope-of-authority or content changes needed after your directive has been witnessed should be made by completing a new directive. First-time changes can be made by lining out anything in the directive and writing “deleted” beside that clause or section (or initialing above any word(s) you have lined out), followed by your signature, and the signature of at least one of the persons serving as a witness to this document, placed in the margin immediately beside the change.

If you are **unable to write**, you may tell your directive witnesses what you want to have excluded, limited, or added to this directive. They must then sign, date, witness and/or notarize the statement of the limitations and exclusions as you have described them. Remember, unless

you direct otherwise, this directive will **only** be used to guide your family and doctors if you are unable to make and communicate medical treatment decisions for yourself.

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***Instructions for Completing the Directive:***

To complete each document, you should ***initial*** in the underlined spaces provided beside all the questions that are asked, and fill in any blank lines as directed. Feel free to write “No,” “None,” or “Does Not Apply” in areas that would otherwise be left blank.

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**Hawaii:**

**ADVANCE HEALTH-CARE DIRECTIVE**

*(Pursuant to HRS. Vol.6: Ch.327E: §327E-1 to §327E-16)*

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1. INTRODUCTION: *The following form may be used to create an advance health-care directive. This form may be modified to suit the needs of the person, or a completely different form may be used that contains the substance of the following form.*

***Document Explanation***

You have the right to give instructions about your own health care. You also have the right to name someone else to make health-care decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding the designation of your health-care provider. If you use this form, you may complete or modify all or any part of it. You are free to use a different form.

**Part 1** of this form is a power of attorney for health care. Part 1 lets you name another individual as agent to make health-care decisions for you if you become incapable of making your own decisions or if you want someone else to make those decisions for you now even though you are still capable. You may name an alternate agent to act for you if your first choice is not willing, able, or reasonably available to make decisions for you. Unless related to you, your agent may not be an owner, operator, or employee of a health-care institution where you are receiving care.

Unless the form you sign limits the authority of your agent, your agent may make all health-care decisions for you. This form has a place for you to limit the authority of your agent. You need not limit the authority of your agent if you wish to rely on your agent for all health-care decisions that may have to be made. If you choose not to limit the authority of your agent, your agent will have the right to:

- 1) Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition;
- 2) Select or discharge health-care providers and institutions;
- 3) Approve or disapprove diagnostic tests, surgical procedures, programs of medication, and orders not to resuscitate; and
- 4) Direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care.

**Part 2** of this form lets you give specific instructions about any aspect of your health care. Choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive, including the provision of artificial nutrition and hydration, as well as the provision of pain relief medication. Space is provided for you to add to the choices you have made or for you to write out any additional wishes.

**Part 3** allows you to express your wishes about organ and tissue donation.

**Part 4** of this form lets you designate a physician to have primary responsibility for your health care.

After completing this form, sign and date the form at the end and have the form witnessed by one of the two alternative methods provided. Give a copy of the signed and completed form to your physician, to any other health-care providers you may have, to any health-care institution at which you are receiving care, and to any health-care agents you have named. You should talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take the responsibility. You have the right to revoke this advance health-care directive or replace this form at any time.

**PART 1  
DURABLE POWER OF ATTORNEY  
FOR HEALTH-CARE DECISIONS**

(1) DESIGNATION OF AGENT: Be it known that I ~~

**Full Legal Name:** \_\_\_\_\_  
**Date of Birth:** \_\_\_\_\_  
**Street Address:** \_\_\_\_\_  
**City:** \_\_\_\_\_ **County:** \_\_\_\_\_  
**State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

~~ designate the following individual as my agent to make health-care decisions for me:

**Name of Agent:** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
**Telephone: Home:** \_\_\_\_\_ **Work:** \_\_\_\_\_  
**Cell Phone or Pager:** \_\_\_\_\_ **E-mail:** \_\_\_\_\_

*OPTIONAL:* If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health-care decision for me, I designate as my first alternate agent:

**Name of Alternate #1:** \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone: Home: \_\_\_\_\_ Work: \_\_\_\_\_  
Cell Phone or Pager: \_\_\_\_\_ E-mail: \_\_\_\_\_

*OPTIONAL:* If I revoke the authority of my agent and first alternate agent or if neither is willing, able, or reasonably available to make a health-care decision for me, I designate as my second alternate agent:

**Name of Alternate #2:** \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone: Home: \_\_\_\_\_ Work: \_\_\_\_\_  
Cell Phone or Pager: \_\_\_\_\_ E-mail: \_\_\_\_\_

(2) AGENT'S AUTHORITY: My agent is authorized to make all health-care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration, and all other forms of health care to keep me alive, except as I state here:

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

*(Add additional sheets if needed.)*

(3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when my primary physician determines that I am unable to make my own health-care decisions unless I initial the following box.

My agent's authority to make health-care decisions for me takes effect immediately.

(4) AGENT'S OBLIGATION: My agent shall make health-care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health-care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

(5) NOMINATION OF GUARDIAN: If a guardian needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able, or reasonably available to act as guardian, I nominate the alternate agents whom I have named, in the order designated.

**PART 2**  
**INSTRUCTIONS FOR HEALTH CARE**

If you are satisfied to allow your agent to determine what is best for you in making end-of-life decisions, you need not fill out this part of the form. If you do fill out this part of the form, you may strike any wording you do not want.

(6) END-OF-LIFE DECISIONS: I direct that my health-care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below (*initial only one box*):

- (a) *Choice Not To Prolong Life*. I do not want my life to be prolonged if:
- (i) I have an incurable and irreversible condition that will result in my death within a relatively short time,
  - (ii) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or
  - (iii) the likely risks and burdens of treatment would outweigh the expected benefits, OR

(b) *Choice To Prolong Life*. I want my life to be prolonged as long as possible within the limits of generally accepted health-care standards.

(7) ARTIFICIAL NUTRITION AND HYDRATION: Artificial nutrition and hydration must be provided, withheld or withdrawn in accordance with the choice I have made in paragraph (6) unless I initial the following box.

Artificial nutrition and hydration must be provided regardless of my condition and regardless of the choice I have made in paragraph (6).

(8) RELIEF FROM PAIN: If I initial the following box, treatment for pain and discomfort will be provided, even if it may unintentionally hasten my death.

I direct that treatment to alleviate pain or discomfort should be provided to me even if it hastens my death.

(9) OTHER WISHES: (*If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.*) I direct that: \_\_\_\_\_

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

(Add additional sheets if needed.)

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

(10) Upon my death: (mark applicable box)

(a) I give any needed organs, tissues, or parts, OR

(b) I give the following organs, tissues, or parts only

(c) My gift is for the following purposes *(strike any of the following you do not want)*

(i) Transplant

(ii) Therapy

(iii) Research

(iv) Education

**PART 4**  
**PRIMARY PHYSICIAN**  
*(OPTIONAL)*

(11) I designate the following physician as my primary physician:

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

Facility/Office: \_\_\_\_\_

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

Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

*OPTIONAL:* If the physician I have designated above is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician:

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

Facility/Office: \_\_\_\_\_

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

Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

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

(13) SIGNATURES: Sign and date the form here:

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

At: (City) \_\_\_\_\_ (State) \_\_\_\_\_

(14) WITNESSES: This power of attorney will not be valid for making health-care decisions unless it is either (a) signed by two qualified adult witnesses who are personally known to you and who are present when you sign or acknowledge your signature; or (b) acknowledged before a notary public in the State.

**ALTERNATIVE NO. 1**

***Statement of First Witness***

I declare under penalty of false swearing pursuant to section 710-1062, Hawaii Revised Statutes, that the principal is personally known to me, that the principal signed or acknowledged this power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, that I am not the person appointed as agent by this document, and that I am not a health-care provider, nor an employee of a health-care provider or facility. I am not related to the principal by blood, marriage, or adoption, and to the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

1<sup>st</sup> Witness: \_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Name Printed) (Date)

\_\_\_\_\_  
(Residence Address)

***Statement of Second Witness***

I declare under penalty of false swearing pursuant to section 710-1062, Hawaii Revised Statutes, that the principal is personally known to me, that the principal signed or acknowledged this power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, that I am not the person appointed as agent by this document, and that I am not a health-care provider, nor an employee of a health-care provider or facility.

2<sup>nd</sup> Witness: \_\_\_\_\_  
(Signature)  
\_\_\_\_\_  
(Name Printed) (Date)  
\_\_\_\_\_  
(Residence Address)

**ALTERNATIVE NO. 2**

State of Hawaii

County of \_\_\_\_\_

On this \_\_\_\_\_ day of \_\_\_\_\_, in the year 20\_\_\_\_\_,  
before me, \_\_\_\_\_ (*insert name of notary public*)  
appeared \_\_\_\_\_,  
personally known to me (*or proved to me on the basis of satisfactory evidence*) to be the person  
whose name is subscribed to this instrument, and acknowledged that he or she executed it.

**Notary Seal**

\_\_\_\_\_  
(*Signature of Notary Public*)