Advance Directive

Revision Date: 6/1/2026

Clinica Sierra Vista

`

This page is blank intentionally

Table of contents

Introduction **4**

Advance Care Planning 4

Choosing your healthcare agent **5**

Role of a healthcare agent 5

Your values and goals **7**

Authorization for Caregiver for Adults/Appointed Representative **10**

Caregiver's Authorization Affidavit **11**

Additional Information 12

Organ and tissue donation (optional) **12**

Body donation (optional) 13

Signing the form **13**

Two witnesses sign the form **14**

Notary public **16**

Introduction

Advance Care Planning

At Clinica Sierra Vista, we are committed to being your partner in making healthcare decisions. Our goal is to provide high-quality, compassionate care that supports each patient's individual health goals. We believe it is essential for you to be fully informed about your health and to feel empowered to share your personal preferences and priorities.

When your healthcare team understands what matters most to you, they can better use their medical expertise to support your goals and provide care that reflects your values.

Advance care planning allows you to work closely with your healthcare team so they understand your wishes and can incorporate them into future care decisions. We encourage you to think about your values, preferences, and the type of care you would want to receive. This may include considering what quality of life is most important to you, what activities you value, and what medical situations you would want to avoid.

You can discuss your wishes with your healthcare team and document them in this form. You also have the option to identify a healthcare agent - someone you trust to make decisions on your behalf if you are unable to do so.

This advance directive form is intended to help you record and communicate your healthcare preferences.

Use this advance directive to direct your future medical care as follows:

Pages 2 – 4: Identify and write down your values and healthcare goals

Pages 5 – 6: Appoint a person who could speak for you if you can't speak for yourself

Page 7: Consider organ donation

Pages 8 – 10: Sign the form with witnesses or a notary present to make it legal

After you have completed your advanced directive, discuss it with your healthcare team.

Choosing your healthcare agent

A **healthcare agent** is the person you choose to make medical decisions for you when you can no longer make them for yourself. This may be the person who cares the most about you, the person you are closest to, or the person you feel fulfills your wishes. You will appoint your healthcare agent in this advance directive.

> **What is the Power of Attorney for Health Care?**
> In California, naming a healthcare agent is part of a legal document called a Power of Attorney for Health Care, which is included in an Advance Health Care Directive. This allows you to choose someone you trust to make medical decisions for you if you are unable to communicate or make decisions for yourself. Your healthcare agent will use your wishes and values to guide these decisions.

You should talk with the person that you choose to be your healthcare agent for two reasons:

- to make sure your healthcare agent knows that he or she is your healthcare agent
- to make sure your healthcare agent knows about your healthcare goals and values so he or she can make the decisions you would want

Most people choose a spouse, child or sibling to be their healthcare agent, but your healthcare agent can be another relative or a close friend.

Role of a healthcare agent

Your healthcare agent will be able to make nearly any medical decision that you could make for yourself.

Your healthcare agent will be able to:

- speak with your healthcare team about your condition and treatment options
- choose healthcare providers and the location of medical treatment
- review your medical record and authorize its release when needed
- accept or refuse medical treatments, including artificial nutrition and hydration and CPR
- decide about tissue and organ donation and autopsy
- decide about care for your body after death

Your healthcare agent should be:

- legally able to serve as your agent (at least 18 years old and not your healthcare provider or an employee of your provider, unless this person is your spouse or a close relative)
- available when needed and willing to make decisions on your behalf
- comfortable asking questions of your healthcare team and able to make the healthcare decisions you would want

Healthcare Agents

You must name a Primary Healthcare Agent. The alternative agents are optional and will serve only if the Primary Agent is unavailable or unwilling to act.

Primary Healthcare Agent (Required)

Name: _____

Relationship: _____

Phone: _____ Email: _____

First Alternate Healthcare Agent (Optional)

Name: _____

Relationship: _____

Phone: _____ Email: _____

Second Alternate Healthcare Agent (Optional)

Name: _____

Relationship: _____

Phone: _____ Email: _____

Your values and goals

Your healthcare team will use medical treatments to try to achieve your goals. When people are seriously ill, many people think about treatment goals in terms of how they are willing to live.

I would not want medical treatments to try to keep me alive if I could no longer:
(Check each statement you agree with)

- ☐ live without being permanently hooked up to a breathing machine
- ☐ recognize family and friends talk to family and friends
- ☐ feed, bathe or take care of myself
- ☐ live without severe pain or discomfort
- ☐ think well enough to make everyday decisions
- ☐ Other: _____

_____

_____

☐ None of the above apply. My life is always worth living, no matter how sick I am.

Sometimes when a person is very sick, life-support treatments are used while the healthcare team tries to help the person get better. These treatments may include CPR, a breathing tube or dialysis. Considering the statements that you chose above, would you want to receive life-support treatments:

(Choose one)

- ☐ **Never**, under any circumstances
- ☐ **Only** if the chances are **high** of surviving to live in a way acceptable to me
- ☐ If the chances are at least **moderate** of surviving to live in a way acceptable to me
- ☐ **Even** if the chances are **low** of surviving to live in a way acceptable to me
- ☐ I would want my healthcare agent to decide this for me, if needed

For more information about life-support treatments, ask your physician.

If you have wishes or thoughts about receiving or not receiving life-support treatments like CPR, a breathing tube, dialysis, feeding tube or other treatments, such as blood transfusions, write them here. These wishes will be used as healthcare instructions to your healthcare agent.

Please write any other beliefs or values that you would want your healthcare agent to know if you become unable to speak for yourself.

Is there anything you want your healthcare team to know about your religion or spirituality?

Is there a religious/spiritual leader from the community you want to be involved?
(Provide contact information)

_____

_____

_____

If I am so ill that I will not recover, I would prefer to die, if possible:
(Choose one or more of the following options)

- ☐ At home under the care of hospice
- ☐ In the hospital
- ☐ In a skilled nursing facility
- ☐ Not sure, my healthcare agent can decide this
- ☐ Where I die is not important to me

Authorization for Caregiver for Adults/Appointed Representative

This is an important medical form. Before signing this form, you should understand what this form allows the person below to do. Please review this document carefully before signing. Form ***is not valid for behavioral health–related services****, such* ***as mental health, substance use disorder (SUD), or psychiatry services.*** *Separate documentation is required for those services.*

Patient Name: _____

Patient DOB: _____ MRN: _____

This form gives the person you choose the right to (please initial each line):

_____ Make, change, or cancel appointments for you. Including checking in for scheduled appointments, receiving voicemails, calls, text messages and/or emails.
_____ Collect any documents on your behalf. This does not include medical records (including, but not limited to, progress notes, medication lists, and past medical history).
_____ Assistance with communication for medication, procedure, or referral needs.
_____ Payment for medical services received.

Additional Conditions:

_____ I understand that this form does NOT allow the person noted below to make healthcare decisions for me. In the state of California, in order to appoint someone to make medical decisions on my behalf I will need to provide an Advance Directive or notarized document showing Power of Attorney.

Name of appointed Caregiver or Authorized Representative (appointee): _____

Appointee Relationship to Patient: _____

Appointee Phone Number: _____

This form shall remain in effect from the date signed, as preferred and specified. Please select one of the following options. Any conditions of this document may be stated here (if you would like the form to expire earlier or later than 1 year, please state so here): _____

☐ One (1) years ☐ Two (2) years ☐ Five (5) years ☐ Ten (10) years

_____	_____	_____
Patient Name	Patient Signature	Date
_____	_____	_____
Appointee Name	Appointee Signature	Date

Caregiver's Authorization Affidavit

Use of this affidavit is authorized by Part 1.5 (commencing with Section 6550) of Division 11 of the California Family Code.

Instructions: Completion of items 1-4 and the signing of the affidavit is sufficient to authorize enrollment of a minor in school and authorize school-related medical care. Completion of items 5 through 8 is additionally required to authorize any other medical care. Print clearly.

The minor named below lives in my home and I am 18 years of age or older.

1. Name of minor: _____
2. Minor's birth date: _____
3. My name (adult giving authorization): _____
4. My house address: _____
   _____
5. ☐ I am a grandparent, aunt, uncle, or other qualified relative of the minor (see next page for a definition of 'qualified relative').
6. Check one or both (for example if one parent was advised and the other cannot be located):
   - ☐ I have advised the parent(s) or other person(s) to have legal custody of the minor of my intent to authorize medical care and have received no objection.
   - ☐ I can contact the parent(s) or other person(s) having legal custody of the minor at this time, to notify them of my intended authorization.
7. My date of birth: _____
8. My California driver's license or identification card number: _____

Warning: Do not sign this form if any of the statements above are incorrect, or you will be committing a crime punishable by a fine, imprisonment, or both.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Dated: _____ Signed: _____

Notices

1. **This declaration does not affect the rights of the minor's parents or legal guardian regarding the care, custody, and control of the minor, and does not mean that the caregiver has legal custody of the minor.**
2. **A person who relies on this affidavit has no obligation to make any further inquiry or investigation.**
3. **This affidavit is not valid for more than one year after the date on which it is executed.**

Additional Information

To Caregivers:

1. "Qualified relative", for purposes of item 5, means a spouse, parent, stepparent, brother, sister, stepbrother, stepsister, half-brother, half-sister, uncle, aunt, niece, nephew, first cousin, or any person denoted by the prefix "grand" or "great" or the spouse of any of the persons specified in this definition, even after the marriage has been terminated by death or dissolution.
2. The law may require you, if you are not a relative or a currently licensed foster parent, to obtain a foster home license in order to care for a minor. If you have any questions, please contact your local department of social services.
3. If the minor stops living with you, you are required to notify any school, health care provider, or health care service plan to which you have given this affidavit.
4. If you do not have the information requested in item 8 (California driver's license or I.D.), provide another form of identification such as your social security number or Medi-Cal number.

To School Officials:

1. Section 48204 of the Education Code provides that this affidavit constitutes a sufficient basis for a determination of residency of the minor, without the requirement of a guardianship or other custody order, unless the school district determines from actual facts that the minor is not living with the caregiver.
2. The school district may require additional reasonable evidence that the caregiver lives at the address provided in item 4.

To Health Care Providers and Health Care Services Plans:

1. No person who acts in good faith reliance upon a caregiver's authorization affidavit to provide medical or dental care, without actual knowledge of facts contrary to those dated on the affidavit, is subject to criminal liability or to civil liability to any person, or is subject to professional disciplinary action, for such reliance if the applicable portions of the form are completed.
2. This affidavit does not confer dependency for health care coverage purposes.

Organ and tissue donation (optional)

Donating your organs and tissues when you die can save the lives of others. Indicate below whether you want to donate your organs.

☐ **I want** my organs donated when I die. Which organs do you want to donate?

- ☐ any organ
- ☐ only (specify): _____

☐ **I do not** want to donate my organs.

☐ I would want my healthcare agent to decide.

To learn more about which organs or tissues can be donated, or to register as an organ donor with the state of California, visit donatelifecalifornia.org

Body donation (optional)

Whole Body Donation for Medical Education and Research Donating your body for medical education and research can help train future healthcare professionals and advance scientific knowledge.

☐ I am interested in donating my body after death.

If you select this option, additional planning is required.

Please speak with your healthcare provider or contact a body donation program directly for more information.

Is there anything that you would like your healthcare providers to know about how you want your body to be cared for after you die?

_____

_____

_____

_____

_____

_____

Signing the form

This form cannot be used by your healthcare providers to honor your wishes until you sign the form and:

Get two witnesses to sign the form	**or**	Have it notarized by a state licensed notary public

Sign your name and write the date in the presence of two witnesses or a notary.

First name _____ Last name_____

Relationship _____

Address _____

City _____ State _____ Zip Code _____

Home phone _____ E-mail _____

Work phone _____

Mobile phone _____

Two witnesses sign the form

If you have two witnesses, have them sign below.
If not, take this form to a notary public.

Your witnesses must
- be over 18 years of age
- know you
- see you sign this form

Your witnesses cannot
- be your healthcare agent
- be your healthcare provider
- work for your healthcare provider
- work at the nursing home where you live (if you live in a nursing home)

Also, one of the witnesses cannot:
- be related to you in any way
- benefit it financially (get any (money or property) after you die

Have your witnesses sign their names and write the date.

By signing, I confirm that _____ signed this form while I watched.

He/she was thinking clearly and was not forced to sign this form.

I also confirm that the following are true:

- I know him/her or this person could prove who he/she is
- I am 18 years or older
- I am not his/her healthcare agent
- I am not his/her healthcare provider and don't work for his/her healthcare provider
- I do not work where he/she lives (if living in a nursing home)

Witness #1

First name _____ Last name_____

Relationship _____

Address _____

City _____ State _____ Zip Code _____

Home phone _____ E-mail _____

Work phone _____

Mobile phone _____

Witness #2

First name _____ Last name_____

Relationship _____

Address _____

City _____ State _____ Zip Code _____

Home phone _____ E-mail _____

Work phone _____

Mobile phone _____

Witness 1 or 2 also must sign the statement below:

I also confirm that the following are true:

- I am not related to the person who signed this form by blood, marriage or adoption
- I will not benefit financially (receive money or property) after he/she dies

Signature _____

This advance directive is now complete. Share this form with your healthcare team, healthcare agent and family. You have the right to revoke or change this advance directive at any time.

Notary public

If two witnesses have not signed this form, take this form to a notary public.
Please bring a government-issued photo I.D. (driver's license, passport, etc.)

YOU MAY USE THIS CERTIFICATE OF ACKNOWLEDGMENT BEFORE
A NOTARY PUBLIC INSTEAD OF THE STATEMENT OF WITNESSES.

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California, County of _____

On (date) _____ before me, (name and title of the officer) _____ personally appeared [name(s) of signer(s)] _____ , who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/ her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal. [Civil Code Section 1189]

Signature _____
**(Notary Public)*

This advance directive is now complete. Please share this form with your healthcare team, your designated healthcare agent, and your family members. This document should be included in your medical record at Clinica Sierra Vista. You have the right to update or cancel this advance directive at any time.