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By: **Senator Forehand**
Introduced and read first time: January 26, 2005
Assigned to: Education, Health, and Environmental Affairs

Committee Report: Favorable with amendments
Senate action: Adopted
Read second time: February 18, 2005

CHAPTER_____

AN ACT concerning

Health Care Decision Making Forms - Health Insurance Portability and Accountability Act - Personal Representatives

FOR the purpose of ~~authorizing~~ clarifying that a health care agent ~~to act as~~ is a personal representative in order to receive certain health care information in accordance with the Health Insurance Portability and Accountability Act; ~~authorizing~~ clarifying that a health care agent ~~to act as~~ is a personal representative regarding certain capacity assessments in accordance with the Health Insurance Portability and Accountability Act; and generally relating to health care decision making forms and personal representatives under the Health Insurance Portability and Accountability Act.

BY repealing and reenacting, with amendments,
Article - Health - General
Section 5-603
Annotated Code of Maryland
(2000 Replacement Volume and 2004 Supplement)

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Laws of Maryland read as follows:

Article - Health - General

5-603.

Health Care Decision Making Forms

The following forms allow you to make some decisions about future health care issues. Form I, called a "Living Will", allows you to make decisions about life-sustaining procedures if, in the future, your death from a terminal condition is imminent despite the application of life-sustaining procedures or you are in a persistent vegetative state. Form II, called an "Advance Directive", allows you to select a health care agent, give health care instructions, or both. If you use the advance directive, you can make decisions about life-sustaining procedures in the event of terminal condition, persistent vegetative state, or end-stage condition. You can also use the advance directive to make any other health care decisions.

These forms are intended to be guides. You can use one form or both, and you may complete all or only part of the forms that you use. Different forms may also be used.

Please note: if you decide to select a health care agent that person may not be a witness to your advance directive. Also, at least one of your witnesses may not be a person who may financially benefit by reason of your death.

Form I
Living Will

(Optional Form)

If I am not able to make an informed decision regarding my health care, I direct my health care providers to follow my instructions as set forth below. (Initial those statements you wish to be included in the document and cross through those statements which do not apply.)

a. If my death from a terminal condition is imminent and even if life-sustaining procedures are used there is no reasonable expectation of my recovery -

_____ I direct that my life not be extended by life-sustaining procedures, including the administration of nutrition and hydration artificially.

_____ I direct that my life not be extended by life-sustaining procedures, except that, if I am unable to take food by mouth, I wish to receive nutrition and hydration artificially.

_____ I direct that, even in a terminal condition, I be given all available medical treatment in accordance with accepted health care standards.

b. If I am in a persistent vegetative state, that is if I am not conscious and am not aware of my environment nor able to interact with others, and there is no reasonable expectation of my recovery within a medically appropriate period -

_____ I direct that my life not be extended by life-sustaining procedures, including the administration of nutrition and hydration artificially.

_____ I direct that my life not be extended by life-sustaining procedures, except that if I am unable to take in food by mouth, I wish to receive nutrition and hydration artificially.

_____ I direct that I be given all available medical treatment in accordance with accepted health care standards.

c. If I am pregnant my agent shall follow these specific instructions:

.....
.....
.....

d. Upon my death, I wish to donate:

_____ Any needed organs, tissues, or eyes.

_____ Only the following organs, tissues, or eyes:

.....
.....

I authorize the use of my organs, tissues, or eyes:

_____ For transplantation

_____ For therapy

_____ For research

_____ For medical education

_____ For any purpose authorized by law.

I understand that before any vital organ, tissue, or eye may be removed for transplantation, I must be pronounced dead. After death, I direct that all support measures be continued to maintain the viability for transplantation of my organs, tissues, and eyes until organ, tissue, and eye recovery has been completed.

I understand that my estate will not be charged for any costs associated with my decision to donate my organs, tissues, or eyes or the actual disposition of my organs, tissues, or eyes.

By signing below, I indicate that I am emotionally and mentally competent to make this living will and that I understand its purpose and effect.

....
(Date) (Signature of Declarant)

The declarant signed or acknowledged signing this living will in my presence and based upon my personal observation the declarant appears to be a competent individual.

....
(Witness) (Witness)

(Signature of Two Witnesses)

Form II

Advance Directive

Part A

Appointment of Health Care Agent

(Optional Form)

(Cross through if you do not want to appoint a health care agent to make health care decisions for you. If you do want to appoint an agent, cross through any items in the form that you do not want to apply.)

(1) I, _____, residing at
_____
appoint the following individual as my agent to make health care decisions for me

.....

.....
(Full Name, Address, and Telephone Number)

Optional: If this agent is unavailable or is unable or unwilling to act as my agent, then I appoint the following person to act in this capacity

.....

.....

(Full Name, Address, and Telephone Number)

(2) IN ACCORDANCE WITH THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT, A HEALTH CARE AGENT IS A PERSONAL REPRESENTATIVE AND IS ENTITLED TO REQUEST AND RECEIVE PROTECTED HEALTH INFORMATION.

(3) My agent has full power and authority to make health care decisions for me, including the power to:

a. [Request,] IN ACCORDANCE WITH THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT AND AS MY PERSONAL REPRESENTATIVE, REQUEST, receive, and review any information, oral or written, regarding my physical or mental health, including, but not limited to, medical and hospital records, AND OTHER PROTECTED HEALTH INFORMATION, and consent to disclosure of this information;

b. Employ and discharge my health care providers;

c. Authorize my admission to or discharge from (including transfer to another facility) any hospital, hospice, nursing home, adult home, or other medical care facility; and

d. Consent to the provision, withholding, or withdrawal of health care, including, in appropriate circumstances, life-sustaining procedures.

~~(3)~~ (4)The authority of my agent is subject to the following provisions and limitations:

.....

.....

.....

~~(4)~~ (5) My agent's authority becomes operative (initial the option that applies):

_____ When my attending physician and a second physician determine that I am incapable of making an informed decision regarding my health care, PROVIDED HOWEVER, WHEN THIS DOCUMENT IS SIGNED, EACH INDIVIDUAL IDENTIFIED IN PARAGRAPH (1) IS, IN ACCORDANCE WITH THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT, MY PERSONAL REPRESENTATIVE FOR ALL PURPOSES RELATED TO ANY ASSESSMENT OF MY CAPACITY TO MAKE AN INFORMED DECISION REGARDING MY HEALTH CARE; or

_____ When this document is signed.

~~(5)~~ (6) My agent is to make health care decisions for me based on the health care instructions I give in this document and on my wishes as otherwise known to my agent. If my wishes are unknown or unclear, my agent is to make health care decisions for me in accordance with my best interest, to be determined by my agent after considering the benefits, burdens, and risks that might result from a given treatment or course of treatment, or from the withholding or withdrawal of a treatment or course of treatment.

~~(6)~~ (7) My agent shall not be liable for the costs of care based solely on this authorization.

By signing below, I indicate that I am emotionally and mentally competent to make this appointment of a health care agent and that I understand its purpose and effect.

....
(Date) (Signature of Declarant)

The declarant signed or acknowledged signing this appointment of a health care agent in my presence and based upon my personal observation appears to be a competent individual.

....
(Witness) (Witness)

(Signature of Two Witnesses)

Part B
Advance Medical Directive
Health Care Instructions

(Optional Form)

(Cross through if you do not want to complete this portion of the form. If you do want to complete this portion of the form, initial those statements you want to be included in the document and cross through those statements that do not apply.)

If I am incapable of making an informed decision regarding my health care, I direct my health care providers to follow my instructions as set forth below. (Initial all those that apply.)

(1) If my death from a terminal condition is imminent and even if life-sustaining procedures are used there is no reasonable expectation of my recovery -

_____ I direct that my life not be extended by life-sustaining procedures, including the administration of nutrition and hydration artificially.

_____ I direct that my life not be extended by life-sustaining procedures, except that if I am unable to take food by mouth, I wish to receive nutrition and hydration artificially.

(2) If I am in a persistent vegetative state, that is, if I am not conscious and am not aware of my environment or able to interact with others, and there is no reasonable expectation of my recovery -

_____ I direct that my life not be extended by life-sustaining procedures, including the administration of nutrition and hydration artificially.

_____ I direct that my life not be extended by life-sustaining procedures, except that if I am unable to take food by mouth, I wish to receive nutrition and hydration artificially.

(3) If I have an end-stage condition, that is a condition caused by injury, disease, or illness, as a result of which I have suffered severe and permanent deterioration indicated by incompetency and complete physical dependency and for which, to a reasonable degree of medical certainty, treatment of the irreversible condition would be medically ineffective -

_____ I direct that my life not be extended by life-sustaining procedures, including the administration of nutrition and hydration artificially.

_____ I direct that my life not be extended by life-sustaining procedures, except that if I am unable to take food by mouth, I wish to receive nutrition and hydration artificially.

(4) I direct that no matter what my condition, medication not be given to me to relieve pain and suffering, if it would shorten my remaining life.

(5) I direct that no matter what my condition, I be given all available medical treatment in accordance with accepted health care standards.

(6) If I am pregnant, my decision concerning life-sustaining procedures shall be modified as follows:

.....
.....
.....

(7) Upon my death, I wish to donate:

_____ Any needed organs, tissues, or eyes.

_____ Only the following organs, tissues, or eyes:

.....
.....

I authorize the use of my organs, tissues, or eyes:

_____ For transplantation

_____ For therapy

_____ For research

_____ For medical education

_____ For any purpose authorized by law.

I understand that before any vital organ, tissue, or eye may be removed for transplantation, I must be pronounced dead. After death, I direct that all support measures be continued to maintain the viability for transplantation of my organs, tissues, and eyes until organ, tissue, and eye recovery has been completed.

I understand that my estate will not be charged for any costs associated with my decision to donate my organs, tissues, or eyes or the actual disposition of my organs, tissues, or eyes.

(8) I direct (in the following space, indicate any other instructions regarding receipt or nonreceipt of any health care)

.....
.....
.....

By signing below, I indicate that I am emotionally and mentally competent to make this advance directive and that I understand the purpose and effect of this document.

....
(Date) (Signature of Declarant)

The declarant signed or acknowledged signing the foregoing advance directive in my presence and based upon personal observation appears to be a competent individual.

....
(Witness) (Witness)

(Signature of Two Witnesses)

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 2005.