J1 6lr2624
CF 6lr2183

By: **Delegates Hubbard, Bobo, and Frush**
Introduced and read first time: February 2, 2006
Assigned to: Health and Government Operations

Committee Report: Favorable with amendments
House action: Adopted
Read second time: March 1, 2006

CHAPTER_____

AN ACT concerning

**Health Care Decisions Act - Advance Directives - Selection of Health Care Agent and Treatment Preferences**

FOR the purpose of clarifying certain forms relating to the selection of certain health care agents, certain treatment preferences, and certain donations; clarifying that certain surrogate decision-makers may make certain decisions when certain health care agents are unavailable; ~~authorizing certain certifications of incapacity to be made by certain physicians or certain psychologists;~~ repealing a certain provision; ~~defining certain terms~~ altering a certain definition; and generally relating to the Health Care Decisions Act.

BY repealing
Article - Health - General
Section 5-603
Annotated Code of Maryland
(2005 Replacement Volume and 2005 Supplement)

BY adding to
Article - Health - General
Section 5-603
Annotated Code of Maryland
(2005 Replacement Volume and 2005 Supplement)

BY repealing and reenacting, with amendments,
Article - Health - General
Section 5-605(a)(1) and (2) ~~and 5-606(a)~~

Annotated Code of Maryland
(2005 Replacement Volume and 2005 Supplement)

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That Section(s) 5-603 of the Health - General Article of the Annotated Code of Maryland be repealed.

SECTION 2. AND BE IT FURTHER ENACTED, That the Laws of Maryland read as follows:

**Article - Health - General**

5-603.

MARYLAND ADVANCE DIRECTIVE:
PLANNING FOR FUTURE HEALTH CARE DECISIONS

BY: _____ DATE OF BIRTH:_____
(PRINT NAME) (MONTH/DAY/YEAR)

USING THIS ADVANCE DIRECTIVE FORM TO DO HEALTH CARE PLANNING IS COMPLETELY OPTIONAL. OTHER FORMS ARE ALSO VALID IN MARYLAND. NO MATTER WHAT FORM YOU USE, TALK TO YOUR FAMILY AND OTHERS CLOSE TO YOU ABOUT YOUR WISHES.

THIS FORM HAS TWO PARTS TO STATE YOUR WISHES, AND A THIRD PART FOR NEEDED SIGNATURES. PART I OF THIS FORM LETS YOU ANSWER THIS QUESTION: IF YOU CANNOT (OR DO NOT WANT TO) MAKE YOUR OWN HEALTH CARE DECISIONS, WHO DO YOU WANT TO MAKE THEM FOR YOU? THE PERSON YOU PICK IS CALLED YOUR HEALTH CARE AGENT. **MAKE SURE YOU TALK TO YOUR HEALTH CARE AGENT (AND ANY BACK-UP AGENTS) ABOUT THIS IMPORTANT ROLE**. PART II LETS YOU WRITE YOUR PREFERENCES ABOUT EFFORTS TO EXTEND YOUR LIFE IN THREE SITUATIONS: TERMINAL CONDITION, PERSISTENT VEGETATIVE STATE, AND END-STAGE CONDITION. IN ADDITION TO YOUR HEALTH CARE PLANNING DECISIONS, YOU CAN CHOOSE TO BECOME AN ORGAN DONOR AFTER YOUR DEATH BY FILLING OUT THE FORM FOR THAT TOO.

YOU CAN FILL OUT PARTS I AND II OF THIS FORM, OR ONLY PART I, OR ONLY PART II. USE THE FORM TO REFLECT YOUR WISHES, THEN SIGN IN FRONT OF TWO WITNESSES (PART III). IF YOUR WISHES CHANGE, MAKE A NEW ADVANCE DIRECTIVE.

MAKE SURE YOU GIVE A COPY OF THE COMPLETED FORM TO YOUR HEALTH CARE AGENT, YOUR DOCTOR, AND OTHERS WHO MIGHT NEED IT. KEEP A COPY AT HOME IN A PLACE WHERE SOMEONE CAN GET IT IF NEEDED. REVIEW WHAT YOU HAVE WRITTEN PERIODICALLY.

**PART I: SELECTION OF HEALTH CARE AGENT**

A. SELECTION OF PRIMARY AGENT

I SELECT THE FOLLOWING INDIVIDUAL AS MY AGENT TO MAKE HEALTH CARE DECISIONS FOR ME:

NAME: _____

ADDRESS:_____

_____

TELEPHONE NUMBERS: _____
(HOME AND CELL)

B. SELECTION OF BACK-UP AGENTS
(OPTIONAL; FORM VALID IF LEFT BLANK)

1. IF MY PRIMARY AGENT CANNOT BE CONTACTED IN TIME OR FOR ANY REASON IS UNAVAILABLE OR UNABLE OR UNWILLING TO ACT AS MY AGENT, THEN I SELECT THE FOLLOWING PERSON TO ACT IN THIS CAPACITY:

NAME: _____

ADDRESS:_____

_____

TELEPHONE NUMBERS: _____
(HOME AND CELL)

2. IF MY PRIMARY AGENT AND MY FIRST BACK-UP AGENT CANNOT BE CONTACTED IN TIME OR FOR ANY REASON ARE UNAVAILABLE OR UNABLE OR UNWILLING TO ACT AS MY AGENT, THEN I SELECT THE FOLLOWING PERSON TO ACT IN THIS CAPACITY:

NAME: _____

ADDRESS:_____

_____

TELEPHONE NUMBERS: _____
(HOME AND CELL)

C. POWERS OF HEALTH CARE AGENT

I WANT MY AGENT TO HAVE FULL POWER TO MAKE HEALTH CARE DECISIONS FOR ME, INCLUDING THE POWER TO:

1. CONSENT OR NOT CONSENT TO MEDICAL PROCEDURES AND TREATMENTS WHICH MY DOCTORS OFFER, INCLUDING THINGS THAT ARE INTENDED TO KEEP ME ALIVE, LIKE VENTILATORS AND FEEDING TUBES;

2. DECIDE WHO MY DOCTOR AND OTHER HEALTH CARE PROVIDERS SHOULD BE; AND

3. DECIDE WHERE I SHOULD BE TREATED, INCLUDING WHETHER I SHOULD BE IN A HOSPITAL, NURSING HOME, OTHER MEDICAL CARE FACILITY, OR HOSPICE PROGRAM.

I WANT MY AGENT TO BE ABLE TO VISIT ME IF I AM IN A HOSPITAL OR ANY OTHER MEDICAL CARE FACILITY.

**THIS ADVANCE DIRECTIVE DOES NOT MAKE MY AGENT RESPONSIBLE FOR ANY OF THE COSTS OF MY CARE.**

THIS POWER IS SUBJECT TO THE FOLLOWING CONDITIONS OR LIMITATIONS: (OPTIONAL; FORM VALID IF LEFT BLANK)

_____
_____
_____
_____
_____

D. HOW MY AGENT IS TO DECIDE SPECIFIC ISSUES

I TRUST MY AGENT'S JUDGMENT. MY AGENT SHOULD LOOK FIRST TO SEE IF THERE IS ANYTHING IN PART II OF THIS ADVANCE DIRECTIVE THAT HELPS DECIDE THE ISSUE. THEN, MY AGENT SHOULD THINK ABOUT THE CONVERSATIONS WE HAVE HAD, MY RELIGIOUS OR OTHER BELIEFS AND VALUES, MY PERSONALITY, AND HOW I HANDLED MEDICAL AND OTHER IMPORTANT ISSUES IN THE PAST. IF WHAT I WOULD DECIDE IS STILL UNCLEAR, THEN MY AGENT IS TO MAKE DECISIONS FOR ME THAT MY AGENT BELIEVES ARE IN MY BEST INTEREST. IN DOING SO, MY AGENT SHOULD CONSIDER THE BENEFITS, BURDENS, AND RISKS OF THE CHOICES PRESENTED BY MY DOCTORS.

E. PEOPLE MY AGENT SHOULD CONSULT
(OPTIONAL; FORM VALID IF LEFT BLANK)

IN MAKING IMPORTANT DECISIONS ON MY BEHALF, I ENCOURAGE MY AGENT TO CONSULT WITH THE FOLLOWING PEOPLE. BY FILLING THIS IN, I DO NOT INTEND TO LIMIT THE NUMBER OF PEOPLE WITH WHOM MY AGENT MIGHT WANT TO CONSULT OR MY AGENT'S POWER TO MAKE THESE DECISIONS.

| NAME(S) | TELEPHONE NUMBER(S) |
| --- | --- |
| _____ | _____ |

_____ _____

_____ _____

_____ _____

_____ _____

F. IN CASE OF PREGNANCY
(OPTIONAL, FOR WOMEN OF CHILD-BEARING YEARS ONLY; FORM VALID IF LEFT BLANK)

IF I AM PREGNANT, MY AGENT SHALL FOLLOW THESE SPECIFIC INSTRUCTIONS:

_____
_____
_____

G. ACCESS TO MY HEALTH INFORMATION - FEDERAL PRIVACY LAW (HIPAA) AUTHORIZATION

1. IF, PRIOR TO THE TIME THE PERSON SELECTED AS MY AGENT HAS POWER TO ACT UNDER THIS DOCUMENT, MY DOCTOR WANTS TO DISCUSS WITH THAT PERSON MY CAPACITY TO MAKE MY OWN HEALTH CARE DECISIONS, I AUTHORIZE MY DOCTOR TO DISCLOSE PROTECTED HEALTH INFORMATION WHICH RELATES TO THAT ISSUE.

2. ONCE MY AGENT HAS FULL POWER TO ACT UNDER THIS DOCUMENT, MY AGENT MAY 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.

3. FOR ALL PURPOSES RELATED TO THIS DOCUMENT, MY AGENT IS MY PERSONAL REPRESENTATIVE UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA). MY AGENT MAY SIGN, AS MY PERSONAL REPRESENTATIVE, ANY RELEASE FORMS OR OTHER HIPAA-RELATED MATERIALS.

H. EFFECTIVENESS OF THIS PART
(READ BOTH OF THESE STATEMENTS CAREFULLY. THEN, INITIAL ONE ONLY.)

MY AGENT'S POWER IS IN EFFECT:

1. IMMEDIATELY AFTER I SIGN THIS DOCUMENT, SUBJECT TO MY RIGHT TO MAKE ANY DECISION ABOUT MY HEALTH CARE IF I WANT AND AM ABLE TO.

_____

((OR))

2. WHENEVER I AM NOT ABLE TO MAKE INFORMED DECISIONS ABOUT MY HEALTH CARE, EITHER BECAUSE THE DOCTOR IN CHARGE OF MY CARE (ATTENDING PHYSICIAN) DECIDES THAT I HAVE LOST THIS ABILITY **TEMPORARILY**, OR MY ATTENDING PHYSICIAN AND A CONSULTING DOCTOR AGREE THAT I HAVE LOST THIS ABILITY **PERMANENTLY**.

_____

IF THE ONLY THING YOU WANT TO DO IS SELECT A HEALTH CARE AGENT, SKIP PART II. GO TO PART III TO SIGN AND HAVE THE ADVANCE DIRECTIVE WITNESSED. IF YOU ALSO WANT TO WRITE YOUR TREATMENT PREFERENCES, USE PART II. ALSO CONSIDER BECOMING AN ORGAN DONOR, USING THE SEPARATE FORM FOR THAT.

**PART II: TREATMENT PREFERENCES ("LIVING WILL")**

A. STATEMENT OF GOALS AND VALUES
(OPTIONAL; FORM VALID IF LEFT BLANK)

I WANT TO SAY SOMETHING ABOUT MY GOALS AND VALUES, AND ESPECIALLY WHAT'S MOST IMPORTANT TO ME DURING THE LAST PART OF MY LIFE:

_____
_____
_____
_____
_____
_____

B. PREFERENCE IN CASE OF TERMINAL CONDITION

(IF YOU WANT TO STATE YOUR PREFERENCE, INITIAL ONE ONLY. IF YOU DO NOT WANT TO STATE A PREFERENCE HERE, CROSS THROUGH THE WHOLE SECTION.)

**IF MY DOCTORS CERTIFY THAT MY DEATH FROM A TERMINAL CONDITION IS IMMINENT, EVEN IF LIFE-SUSTAINING PROCEDURES ARE USED:**

1. KEEP ME COMFORTABLE AND ALLOW NATURAL DEATH TO OCCUR. I DO NOT WANT ANY MEDICAL INTERVENTIONS USED TO TRY TO EXTEND MY LIFE. I DO NOT WANT TO RECEIVE NUTRITION AND FLUIDS BY TUBE OR OTHER MEDICAL MEANS.

_____

((OR))

2. KEEP ME COMFORTABLE AND ALLOW NATURAL DEATH TO OCCUR. I DO NOT WANT MEDICAL INTERVENTIONS USED TO TRY TO EXTEND MY LIFE. IF I AM UNABLE TO TAKE ENOUGH NOURISHMENT BY MOUTH, HOWEVER, I

WANT TO RECEIVE NUTRITION AND FLUIDS BY TUBE OR OTHER MEDICAL MEANS.

_____

((OR))

3. TRY TO EXTEND MY LIFE FOR AS LONG AS POSSIBLE, USING ALL AVAILABLE INTERVENTIONS IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS.

_____

C. PREFERENCE IN CASE OF PERSISTENT VEGETATIVE STATE

(IF YOU WANT TO STATE YOUR PREFERENCE, INITIAL ONE ONLY. IF YOU DO NOT WANT TO STATE A PREFERENCE HERE, CROSS THROUGH THE WHOLE SECTION.)

**IF MY DOCTORS CERTIFY THAT I AM IN A PERSISTENT VEGETATIVE STATE, THAT IS, IF I AM NOT CONSCIOUS AND AM NOT AWARE OF MYSELF OR MY ENVIRONMENT OR ABLE TO INTERACT WITH OTHERS, AND THERE IS NO REASONABLE EXPECTATION THAT I WILL EVER REGAIN CONSCIOUSNESS:**

1. KEEP ME COMFORTABLE AND ALLOW NATURAL DEATH TO OCCUR. I DO NOT WANT ANY MEDICAL INTERVENTIONS USED TO TRY TO EXTEND MY LIFE. I DO NOT WANT TO RECEIVE NUTRITION AND FLUIDS BY TUBE OR OTHER MEDICAL MEANS.

_____

((OR))

2. KEEP ME COMFORTABLE AND ALLOW NATURAL DEATH TO OCCUR. I DO NOT WANT MEDICAL INTERVENTIONS USED TO TRY TO EXTEND MY LIFE. IF I AM UNABLE TO TAKE ENOUGH NOURISHMENT BY MOUTH, HOWEVER, I WANT TO RECEIVE NUTRITION AND FLUIDS BY TUBE OR OTHER MEDICAL MEANS.

_____

((OR))

3. TRY TO EXTEND MY LIFE FOR AS LONG AS POSSIBLE, USING ALL AVAILABLE INTERVENTIONS IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS.

_____

D. PREFERENCE IN CASE OF END-STAGE CONDITION

(IF YOU WANT TO STATE YOUR PREFERENCE, INITIAL ONE ONLY. IF YOU DO NOT WANT TO STATE A PREFERENCE HERE, CROSS THROUGH THE WHOLE

SECTION.)

**IF MY DOCTORS CERTIFY THAT I AM IN AN END-STAGE CONDITION, THAT IS, AN INCURABLE CONDITION THAT WILL KEEP GETTING WORSE UNTIL DEATH AND THAT HAS ALREADY RESULTED IN LOSS OF CAPACITY AND COMPLETE PHYSICAL DEPENDENCY:**

1. KEEP ME COMFORTABLE AND ALLOW NATURAL DEATH TO OCCUR. I DO NOT WANT ANY MEDICAL INTERVENTIONS USED TO TRY TO EXTEND MY LIFE. I DO NOT WANT TO RECEIVE NUTRITION AND FLUIDS BY TUBE OR OTHER MEDICAL MEANS.

_____

((OR))

2. KEEP ME COMFORTABLE AND ALLOW NATURAL DEATH TO OCCUR. I DO NOT WANT MEDICAL INTERVENTIONS USED TO TRY TO EXTEND MY LIFE. IF I AM UNABLE TO TAKE ENOUGH NOURISHMENT BY MOUTH, HOWEVER, I WANT TO RECEIVE NUTRITION AND FLUIDS BY TUBE OR OTHER MEDICAL MEANS.

_____

((OR))

3. TRY TO EXTEND MY LIFE FOR AS LONG AS POSSIBLE, USING ALL AVAILABLE INTERVENTIONS IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS.

_____

E. PAIN RELIEF

NO MATTER WHAT MY CONDITION, GIVE ME THE MEDICINE OR OTHER TREATMENT I NEED TO RELIEVE PAIN.

_____

F. IN CASE OF PREGNANCY

(OPTIONAL, FOR WOMEN OF CHILD-BEARING YEARS ONLY; FORM VALID IF LEFT BLANK)

IF I AM PREGNANT, MY DECISION CONCERNING LIFE-SUSTAINING PROCEDURES SHALL BE MODIFIED AS FOLLOWS:

_____
_____
_____
_____

G. EFFECT OF STATED PREFERENCES

(READ BOTH OF THESE STATEMENTS CAREFULLY. THEN, INITIAL ONE ONLY.)

1. I REALIZE I CANNOT FORESEE EVERYTHING THAT MIGHT HAPPEN AFTER I CAN NO LONGER DECIDE FOR MYSELF. MY STATED PREFERENCES ARE MEANT TO GUIDE WHOEVER IS MAKING DECISIONS ON MY BEHALF AND MY HEALTH CARE PROVIDERS, BUT I AUTHORIZE THEM TO BE FLEXIBLE IN APPLYING THESE STATEMENTS IF THEY FEEL THAT DOING SO WOULD BE IN MY BEST INTEREST.

_____

((OR))

2. I REALIZE I CANNOT FORESEE EVERYTHING THAT MIGHT HAPPEN AFTER I CAN NO LONGER DECIDE FOR MYSELF. STILL, I WANT WHOEVER IS MAKING DECISIONS ON MY BEHALF AND MY HEALTH CARE PROVIDERS TO FOLLOW MY STATED PREFERENCES EXACTLY AS WRITTEN, EVEN IF THEY THINK THAT SOME ALTERNATIVE IS BETTER.

_____

**PART III: SIGNATURE AND WITNESSES**

BY SIGNING BELOW AS THE DECLARANT, I INDICATE THAT I AM EMOTIONALLY AND MENTALLY COMPETENT TO MAKE THIS ADVANCE DIRECTIVE AND THAT I UNDERSTAND ITS PURPOSE AND EFFECT. I ALSO UNDERSTAND THAT THIS DOCUMENT REPLACES ANY SIMILAR ADVANCE DIRECTIVE I MAY HAVE COMPLETED BEFORE THIS DATE.

_____ _____
(SIGNATURE OF DECLARANT) (DATE)

THE DECLARANT SIGNED OR ACKNOWLEDGED SIGNING THIS DOCUMENT IN MY PRESENCE AND, BASED UPON PERSONAL OBSERVATION, APPEARS TO BE EMOTIONALLY AND MENTALLY COMPETENT TO MAKE THIS ADVANCE DIRECTIVE.

_____ _____
(SIGNATURE OF WITNESS) (DATE)

_____
TELEPHONE NUMBER(S)

_____ _____
(SIGNATURE OF WITNESS) (DATE)

_____
TELEPHONE NUMBER(S)

(NOTE: ANYONE SELECTED AS A HEALTH CARE AGENT IN PART I MAY NOT BE A WITNESS. ALSO, AT LEAST ONE OF THE WITNESSES MUST BE SOMEONE WHO WILL NOT KNOWINGLY INHERIT ANYTHING FROM THE DECLARANT OR OTHERWISE KNOWINGLY GAIN A FINANCIAL BENEFIT FROM THE DECLARANT'S DEATH. MARYLAND LAW DOES **NOT** REQUIRE THIS DOCUMENT TO BE NOTARIZED.)

**AFTER MY DEATH: DONATION OF ORGANS OR BODY**
(THIS FORM IS OPTIONAL. FILL OUT ONLY WHAT REFLECTS YOUR WISHES.)

BY: _____ DATE OF BIRTH:_____
(PRINT NAME) (MONTH/DAY/YEAR)

**PART I: ORGAN DONATION**

(INITIAL THE ONES THAT YOU WANT.)

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 NO VITAL ORGAN, TISSUE, OR EYE MAY BE REMOVED FOR TRANSPLANTATION UNTIL AFTER I HAVE BEEN PRONOUNCED DEAD UNDER LEGAL STANDARDS. **THIS DOCUMENT IS NOT INTENDED TO CHANGE ANYTHING ABOUT MY HEALTH CARE WHILE I AM STILL ALIVE**. AFTER DEATH, I AUTHORIZE ANY APPROPRIATE SUPPORT MEASURES 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 RELATED TO THIS DONATION.

**PART II: DONATION OF BODY**

AFTER ANY ORGAN DONATION INDICATED IN PART I, I WISH MY BODY TO BE DONATED FOR USE IN A MEDICAL STUDY PROGRAM.

_____

**PART III: SIGNATURE AND WITNESSES**

BY SIGNING BELOW, I INDICATE THAT I AM EMOTIONALLY AND MENTALLY COMPETENT TO MAKE THIS DONATION AND THAT I UNDERSTAND THE PURPOSE AND EFFECT OF THIS DOCUMENT.

_____ _____
(SIGNATURE OF DONOR) (DATE)

THE DONOR SIGNED OR ACKNOWLEDGED SIGNING THIS DONATION DOCUMENT IN MY PRESENCE AND, BASED UPON PERSONAL OBSERVATION, APPEARS TO BE EMOTIONALLY AND MENTALLY COMPETENT TO MAKE THIS DONATION.

_____ _____
(SIGNATURE OF WITNESS) (DATE)

_____
TELEPHONE NUMBER(S)

_____ _____
(SIGNATURE OF WITNESS) (DATE)

_____
TELEPHONE NUMBER(S)

5-605.

(a) (1) In this subsection, "unavailable" means:

(i) After reasonable inquiry, a health care provider is unaware of the existence of a HEALTH CARE AGENT OR surrogate decision maker;

(ii) After reasonable inquiry, a health care provider cannot ascertain the whereabouts of a HEALTH CARE AGENT OR surrogate decision maker;

(iii) A HEALTH CARE AGENT OR surrogate decision maker has not responded in a timely manner, taking into account the health care needs of the individual, to a written or oral message from a health care provider;

(iv) A HEALTH CARE AGENT OR surrogate decision maker is incapacitated; or

(v) A HEALTH CARE AGENT OR surrogate decision maker is unwilling to make decisions concerning health care for the individual.

(2) The following individuals or groups, in the specified order of priority, may make decisions about health care for a person who has been certified to be incapable of making an informed decision and who has not appointed a health care agent in accordance with this subtitle OR WHOSE HEALTH CARE AGENT IS UNAVAILABLE. Individuals in a particular class may be consulted to make a decision only if all individuals in the next higher class are unavailable:

(i) A guardian for the patient, if one has been appointed;

(ii) The patient's spouse;

(iii) An adult child of the patient;

(iv) A parent of the patient;

(v) An adult brother or sister of the patient; or

(vi) A friend or other relative of the patient who meets the requirements of paragraph (3) of this subsection.

~~5-606.~~

~~(a) (1) Prior to providing, withholding, or withdrawing treatment for which authorization has been obtained or will be sought under this subtitle, the attending physician and a second physician OR A LICENSED PSYCHOLOGIST, one of whom shall have examined the patient within 2 hours before making the certification, shall certify in writing that the patient is incapable of making an informed decision regarding the treatment. The certification shall be based on a personal examination of the patient.~~

~~(2) If a patient is unconscious, or unable to communicate by any means, the certification of a second physician OR A LICENSED PSYCHOLOGIST is not required under paragraph (1) of this subsection.~~

~~(3) When authorization is sought for treatment of a mental illness, the second physician OR LICENSED PSYCHOLOGIST may not be otherwise currently involved in the treatment of the person assessed.~~

~~(4) The cost of an assessment to certify incapacity under this subsection shall be considered for all purposes a cost of the patient's treatment.~~

SECTION 3. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 2006.