36-3295. Registry information; confidentiality; health care provider access; use and transfer of information; definition

A. Information maintained by the qualifying health information exchange organization pursuant to this article is confidential and shall not be disclosed except as allowed by state or federal law.

B. The person who submits a document described in section 36-3292, the person who is the subject of the document and the surrogate of the person who is the subject of the document may access the document in the health care directives registry in a manner prescribed by the qualifying health information exchange organization.

C. Notwithstanding subsection A of this section, a health care provider may access the health care directives registry and receive a patient's health care directive documents for the provision of health care services.

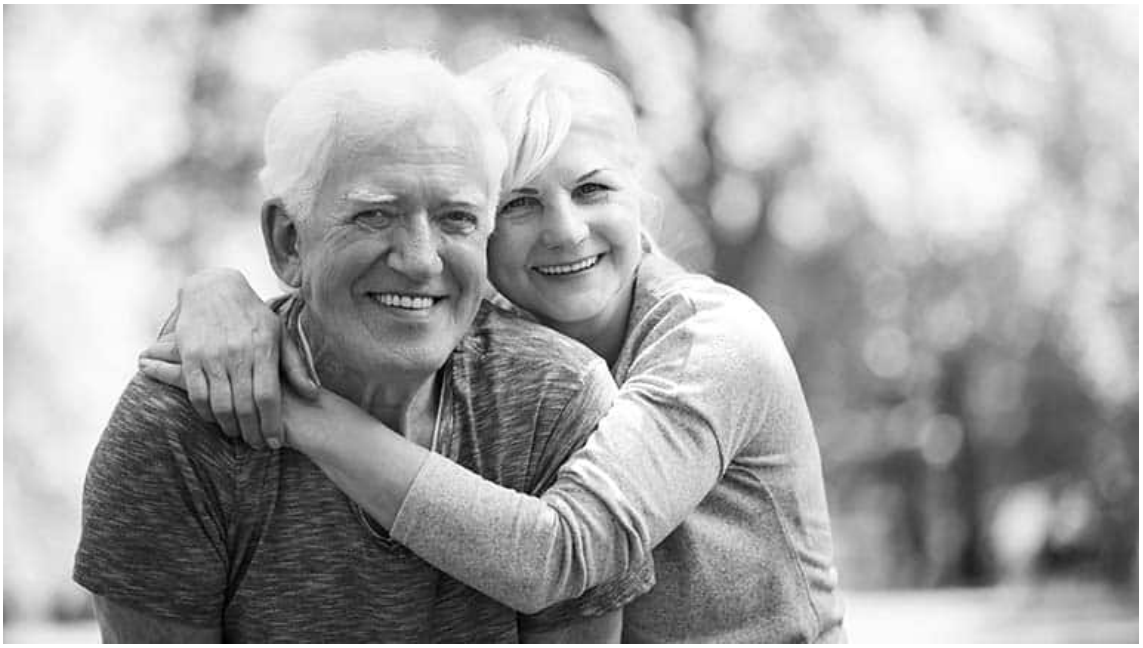
D. The qualifying health information exchange organization shall use information contained in the registry only for purposes prescribed in this article, except that the qualifying health information exchange organization may use, disclose and make accessible the information contained in the registry through the health information organization as authorized by section 36-3805, subsection A.

E. At the request of the person who submitted a document described in section 36-3292, the qualifying health information exchange organization may transmit the information received regarding the document to the registry system of another jurisdiction.

F. For the purposes of this section, "health care provider" includes an emergency medical service provider and emergency service technician providing emergency medical services as defined in section 36-2201 and the organ procurement organization that maintains the donor registry established pursuant to section 36-858.

Arizona Resources for Advance Care Planning | Arizona Healthcare Directives Registry

Casey Bourque



We've compiled a list of resources to help all Arizonans think through, discuss, and prepare advance directives—for themselves and for others.

Advance Care Planning Documents

You can access advance directives forms at no cost in several locations.

Having the Conversation

Legal Resources

Miscellaneous Resources

Videos

English

36-3224. Sample health care power of attorney

Any writing that meets the requirements of section 36-3221 may be used to create a health care power of attorney. The following form is offered as a sample only and does not prevent a person from using other language or another form:

1. Health Care Power of Attorney

I, _____, as principal, designate _____ as my agent for all matters relating to my health care, including, without limitation, full power to give or refuse consent to all medical, surgical, hospital and related health care. This power of attorney is effective on my inability to make or communicate health care decisions. All of my agent's actions under this power during any period when I am unable to make or communicate health care decisions or when there is uncertainty whether I am dead or alive have the same effect on my heirs, devisees and personal representatives as if I were alive, competent and acting for myself.

If my agent is unwilling or unable to serve or continue to serve, I hereby appoint _____ as my agent.

I have _____ I have not _____ completed and attached a living will for purposes of providing specific direction to my agent in situations that may occur during any period when I am unable to make or communicate health care decisions or after my death. My agent is directed to implement those choices I have initialed in the living will.

I have _____ I have not _____ completed a prehospital medical care directive pursuant to section 36-3251, Arizona Revised Statutes.

This health care directive is made under section 36-3221, Arizona Revised Statutes, and continues in effect for all who may rely on it except those to whom I have given notice of its revocation.

_____

Signature of Principal

Witness: _____ Date: _____

_____ Time: _____

Address: _____ _____

_____ _____

Address of Agent

Witness: _____ _____

_____ Telephone of Agent

Address: _____

_____

(Note: This document may be notarized instead of being witnessed.)

2. Autopsy (under Arizona law an autopsy may be required)

If you wish to do so, reflect your desires below:

_____ 1. I do not consent to an autopsy.

_____ 2. I consent to an autopsy.

_____ 3. My agent may give consent to or refuse an autopsy.

3. Organ Donation (Optional)

(Under Arizona law, you may make a gift of all or part of your body to a bank or storage facility or a hospital, physician or medical or dental school for transplantation, therapy, medical or dental evaluation or research or for the advancement of medical or dental science. You may also authorize your agent to do so or a member of your family may make a gift unless you give them notice that you do not want a gift made. In the space below you may make a gift yourself or state that you do not want to make a gift. If you do not complete this section, your agent will have the authority to make a gift of a part of your body pursuant to law. Note: The donation elections you make in this health care power of attorney survive your death.)

If any of the statements below reflects your desire, initial on the line next to that statement. You do not have to initial any of the statements.

If you do not check any of the statements, your agent and your family will have the authority to make a gift of all or part of your body under Arizona law.

_____ I do not want to make an organ or tissue donation and I do not want my agent or family to do so.

_____ I have already signed a written agreement or donor card regarding organ and tissue donation with the following individual or institution: _____

_____ Pursuant to Arizona law, I hereby give, effective on my death:

[] Any needed organ or parts.

[] The following part or organs listed:

_____

_____

_____

for (check one):

[] Any legally authorized purpose.

[] Transplant or therapeutic purposes only.

4. Physician Affidavit (Optional)

(Before initialing any choices above you may wish to ask questions of your physician regarding a particular treatment alternative. If you do speak with your physician it is a good idea to ask your physician to complete this affidavit and keep a copy for his file.)

I, Dr. _____ have reviewed this guidance document and have discussed with _____ any questions regarding the probable medical consequences of the treatment choices provided above. This discussion with the principal occurred on _____.

(date)

I have agreed to comply with the provisions of this directive.

_____

Signature of Physician

5. Living Will (Optional. Section 36-3262, Arizona Revised Statutes, has a sample living will.)

6. Funeral and Burial Disposition (Optional)

My agent has authority to carry out all matters relating to my funeral and burial disposition wishes in accordance with this power of attorney, which is effective upon my death.

My wishes are reflected below:

_____ Upon my death, I direct my body to be buried. (as opposed to cremated)

_____ Upon my death, I direct my body to be buried in _____. (Optional directive)

_____ Upon my death, I direct my body to be cremated.

_____ Upon my death, I direct my body to be cremated, with my ashes to be_____. (Optional directive)

_____ My agent may make all funeral and burial disposition decisions. (Optional directive)

36-3251. Prehospital medical care directives; form; effect; immunity; definitions

A. Notwithstanding any law or a health care directive to the contrary, a person may execute a prehospital medical care directive that, in the event of cardiac or respiratory arrest, directs the withholding of cardiopulmonary resuscitation by emergency medical system personnel, hospital emergency department personnel and, as provided in subsection L of this section, direct care staff persons. For the purposes of this article, "cardiopulmonary resuscitation" includes cardiac compression, endotracheal intubation and other advanced airway management, artificial ventilation, defibrillation, administration of advanced cardiac life support drugs and related emergency medical procedures. Authorization for the withholding of cardiopulmonary resuscitation does not include the withholding of other medical interventions, such as intravenous fluids, oxygen or other therapies deemed necessary to provide comfort care or to alleviate pain.

B. A prehospital medical care directive shall be printed on an orange background and may be used in either letter or wallet size. The directive shall be in the following form:

Prehospital Medical Care Directive

(side one)

In the event of cardiac or respiratory arrest, I refuse any resuscitation measures, including cardiac compression, endotracheal intubation and other advanced airway management, artificial ventilation, defibrillation, administration of advanced cardiac life support drugs and related emergency medical procedures.

Patient: _____ date: _____

(Signature or mark)

Attach recent photograph here or provide all of the following information below:

Date of birth _____ sex ____

Eye color _____ hair color _____ race _____

Hospice program (if any) _____

Name and telephone number of patient's physician

_____

(side two)

I have explained this form and its consequences to the signer and obtained assurance that the signer understands that death may result from any refused care listed above.

_____ date _____

(Licensed health care provider)

I was present when this was signed (or marked). The patient then appeared to be of sound mind and free from duress.

_____ date _____

(Witness)

C. A person who has a valid prehospital medical care directive pursuant to this section may wear an identifying bracelet on either the wrist or the ankle. The bracelet shall be substantially similar to identification bracelets worn in hospitals. The bracelet shall be on an orange background and state the following in bold type:

Do Not Resuscitate

Patient: _____

Patient's physician: _____

D. If the person has designated an agent to make health care decisions under section 36-3221 or has been appointed a guardian for health care decisions pursuant to title 14, that agent or guardian shall sign if the person is no longer competent to do so.

E. A prehospital medical care directive is effective until it is revoked or superseded by a new document.

F. Emergency medical system personnel, hospital emergency department personnel and direct care staff persons who make a good faith effort to identify the patient and who rely on an apparently genuine directive or a photocopy of a directive on orange paper are immune from liability to the same extent and under the same conditions as prescribed in section 36-3205. If a person has any doubt as to the validity of a directive or the medical situation, that person shall proceed with resuscitative efforts as otherwise required by law. Emergency medical system personnel and direct care staff persons are not required to accept or interpret medical care directives that do not meet the requirements of this section.

G. In the absence of a physician, a person without vital signs who is not resuscitated pursuant to a prehospital medical care directive may be pronounced dead by any peace officer of this state, a professional nurse licensed pursuant to title 32, chapter 15 or an emergency medical technician certified pursuant to this title.

H. This section does not apply to situations involving mass casualties or to medical emergencies involving children and adults with disabilities in public or private schools that are not licensed health care institutions as defined in section 36-401.

I. After being notified of a death by emergency medical system personnel, the person's physician or the county medical examiner is then responsible for signing the death certificate.

J. The office of emergency medical services in the department of health services shall print prehospital medical care directive forms and make them available to the public. The department may charge a fee that covers the department's costs to prepare the form. The department and its employees are immune from civil liability for issuing prehospital medical care directive forms that meet the requirements of this section. A person may use a form that is not prepared by the department of health services if that form meets the requirements of this section. If an organization distributes a prehospital medical care directive form that meets the requirements of this section, that organization and its employees are also immune from civil liability.

K. Any prehospital medical care directive prepared before April 24, 1994 is valid if it was valid at the time it was prepared.

L. A direct care staff person may comply with a prehospital medical care directive pursuant to this section if the physician of the person who has the valid prehospital medical care directive has ordered a hospice plan of care.

M. The department of economic security or the Arizona health care cost containment system administration may prescribe guidance for training and education of direct care staff persons regarding the requirements of this section.

N. For the purposes of this section:

1. "Direct care staff person" means a person who is employed or contracted to provide direct services pursuant to title 36, chapter 5.1.

2. "Emergency medical system personnel" includes emergency medical technicians at all levels who are certified by the department of health services and medical personnel who are licensed by this state and who are operating outside of an acute care hospital under the direction of an emergency medical system agency recognized by the department of health services.

36-3262. Sample living will

Any writing that meets the requirements of this article may be used to create a living will. A person may write and use a living will without writing a health care power of attorney or may attach a living will to the person's health care power of attorney. If a person has a health care power of attorney, the agent must make health care decisions that are consistent with the person's known desires and that are medically reasonable and appropriate. A person can, but is not required to, state the person's desires in a living will. The following form is offered as a sample only and does not prevent a person from using other language or another form:

Living Will

(Some general statements concerning your health care options are outlined below. If you agree with one of the statements, you should initial that statement. Read all of these statements carefully before you initial your selection. You can also write your own statement concerning life-sustaining treatment and other matters relating to your health care. You may initial any combination of paragraphs 1, 2, 3 and 4 but if you initial paragraph 5 the others should not be initialed.)

_____ 1. If I have a terminal condition I do not want my life to be prolonged and I do not want life-sustaining treatment, beyond comfort care, that would serve only to artificially delay the moment of my death.

_____ 2. If I am in a terminal condition or an irreversible coma or a persistent vegetative state that my doctors reasonably feel to be irreversible or incurable, I do want the medical treatment necessary to provide care that would keep me comfortable, but I do not want the following:

_____ (a) Cardiopulmonary resuscitation, for example, the use of drugs, electric shock and artificial breathing.

_____ (b) Artificially administered food and fluids.

_____ (c) To be taken to a hospital if at all avoidable.

_____ 3. Notwithstanding my other directions, if I am known to be pregnant, I do not want life-sustaining treatment withheld or withdrawn if it is possible that the embryo/fetus will develop to the point of live birth with the continued application of life-sustaining treatment.

_____ 4. Notwithstanding my other directions I do want the use of all medical care necessary to treat my condition until my doctors reasonably conclude that my condition is terminal or is irreversible and incurable or I am in a persistent vegetative state.

_____ 5. I want my life to be prolonged to the greatest extent possible.

Other or Additional Statements of Desires

I have _____ I have not _____ attached additional special provisions or limitations to this document to be honored in the absence of my being able to give health care directions.

36-3286. Sample mental health care power of attorney

A person may use any writing that meets the requirements of sections 36-3281 and 36-3282 to create a mental health care power of attorney. The following form is offered as a sample only and does not prevent a person from using other language or another form:

Mental Health Care Power of Attorney

I, _____, being an adult of sound mind, voluntarily make this declaration for mental treatment. I want this declaration to be followed if I am incapable, as defined in section 36-3281, Arizona Revised Statutes. I designate _____ as my agent for all matters relating to my mental health care including, without limitation, full power to give or refuse consent to all medical care related to my mental health condition. If my agent is unable or unwilling to serve or continue to serve, I appoint _____ as my agent. I want my agent to make decisions for my mental health care treatment that are consistent with my wishes as expressed in this document or, if not specifically expressed, as are otherwise known to my agent.

If my wishes are unknown to my agent, I want my agent to make decisions regarding my mental health care that are consistent with what my agent in good faith believes to be in my best interests. My agent is also authorized to receive information regarding proposed mental health treatment and to receive, review and consent to disclosure of any medical records relating to that treatment.

This declaration allows me to state my wishes regarding mental health care treatment including medications, admission to and retention in a health care facility for mental health treatment and outpatient services.

This mental health care power of attorney or any portion of it may not be revoked and any designated agent may not be disqualified by me during times that I am found to be unable to give informed consent. However, at all other times I retain the right to revoke all or any portion of this mental health care power of attorney or to disqualify any agent designated by me in this document.

The following are my wishes regarding my mental health care treatment if I become incapable, as defined in section 36-3281, Arizona Revised Statutes:

I consent to the following mental health treatments:

_____

_____

_____

_____

By initialing here, I consent to giving my agent the power to admit me to an inpatient or partial psychiatric hospitalization program, please initial here: ____ (initial if you consent)

I do not consent to the following mental health treatments:

_____

_____

_____

_____

Additional information about my mental health care treatment needs (consider including mental or physical health history, dietary requirements, religious concerns, people to notify and any other matters that you feel are important):

_____

_____

_____

This mental health care power of attorney is made pursuant to title 36, chapter 32, article 6, Arizona Revised Statutes, and continues in effect for all who may rely on it except to those I have given notice of its revocation pursuant to section 36-3285, Arizona Revised Statutes.

_____

(signature of principal)

Address of agent_____

_____

Telephone number of agent_____

Address of backup agent_____

_____

Telephone number of backup agent_____

Affirmation of witnesses:

I affirm that the person signing this mental health care power of attorney:

1. Is personally known to me.

2. Signed or acknowledged by his or her signature on this declaration in my presence.

3. Appears to be of sound mind and not under duress, fraud or undue influence.

4. Is not related to me by blood, marriage or adoption.

5. Is not a person for whom I directly provide care as a professional.

6. Has not appointed me as an agent to make medical decisions on his or her behalf.

Witnessed by:

_____ (signature and date)

_____ (signature and date)

Acceptance of appointment as agent: (optional)

I accept this appointment and agree to serve as agent to make mental health treatment decisions for the principal. I understand that I must act consistently with the wishes of the person I represent, as expressed in this mental health care power of attorney, or if not expressed, as otherwise known by me. If I do not know the principal's wishes, I have a duty to act in what I in good faith believe to be that person's best interests. I understand that this document gives me the authority to make decisions about mental health treatment only while that person has been determined to be incapable as that term is defined in section 36-3281, Arizona Revised Statutes.

_____

(signature of agent)

_____

(printed name of agent)