GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2005

H **D**

HOUSE DRH30121-LN-182 (3/22)

Short Title:	Health Care Power of Atty/Dispos. of Remains.	(Public)
Sponsors:	Representative Tucker.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO PROVIDE THAT IF A VALIDLY EXECUTED HEALTH CARE POWER OF ATTORNEY AUTHORIZES THE HEALTH CARE AGENT TO EXERCISE RIGHTS WITH RESPECT TO ANATOMICAL GIFTS, AUTOPSY, OR DISPOSITION OF THE PRINCIPAL'S REMAINS, THE AUTHORIZING PROVISION WILL CONTINUE IN EFFECT AFTER THE DEATH OF THE PRINCIPAL FOR PURPOSES OF EXERCISING THE AUTHORIZED RIGHTS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 32A-19(b) reads as rewritten:

"**§ 32A-19. Extent of authority; limitations of authority.**

…

(b) A health care power of attorney may authorize the health care agent to exercise any and all rights the principal may have with respect to anatomical gifts, the authorization of any autopsy, and the disposition of remains. If a health care power of attorney authorizes the health care agent to exercise rights with respect to anatomical gifts, autopsy, or disposition of the principal's remains, the authorization survives the termination of the health care power of attorney upon the death of the principal for purposes of exercising the authority granted by the principal.

…."

SECTION 2. G.S. 32A-20(b) reads as rewritten:

"**§ 32A-20. Effectiveness and duration; revocation.**

…

(b) ~~A~~ Except for purposes of exercising authority granted by a health care power of attorney with respect to anatomical gifts, autopsy, or disposition of the principal's remains as provided in G.S. 32A-19(b), a health care power of attorney is revoked by the death of the principal. A health care power of attorney may be revoked by the principal at any time, so long as the principal is capable of making and communicating

health care decisions. The principal may exercise this right of revocation by executing and acknowledging an instrument of revocation, by executing and acknowledging a subsequent health care power of attorney, or in any other manner by which the principal is able to communicate an intent to revoke. This revocation becomes effective only upon communication by the principal to each health care agent named in the revoked health care power of attorney and to the principal's attending physician or eligible psychologist.

…."

SECTION 3. G.S. 32A-25 reads as rewritten:

"**§ 32A-25. Statutory form health care power of attorney.**

The use of the following form in the creation of a health care power of attorney is lawful and, when used, it shall meet the requirements of and be construed in accordance with the provisions of this Article:

(Notice: This document gives the person you designate your health care agent broad powers to make health care decisions, including mental health treatment decisions, for you. Except to the extent that you express specific limitations or restrictions on the authority of your health care agent, this power includes the power to consent to your doctor not giving treatment or stopping treatment necessary to keep you alive, admit you to a facility, and administer certain treatments and medications. This power exists only as to those health care decisions for which you are unable to give informed consent.

This form does not impose a duty on your health care agent to exercise granted powers, but when a power is exercised, your health care agent will have to use due care to act in your best interests and in accordance with this document. For mental health treatment decisions, your health care agent will act according to how the health care agent believes you would act if you were making the decision. Because the powers granted by this document are broad and sweeping, you should discuss your wishes concerning life-sustaining procedures, mental health treatment, and other health care decisions with your health care agent.

Use of this form in the creation of a health care power of attorney is lawful and is authorized pursuant to North Carolina law. However, use of this form is an optional and nonexclusive method for creating a health care power of attorney and North Carolina law does not bar the use of any other or different form of power of attorney for health care that meets the statutory requirements.)

1. Designation of health care agent.

I, ____________, being of sound mind, hereby appoint

Name: ________________________________

Home Address: ____________________________

Home Telephone Number ________Work Telephone Number________

as my health care attorney-in-fact (herein referred to as my "health care agent") to act for me and in my name (in any way I could act in person) to make health care decisions for me as authorized in this document.

If the person named as my health care agent is not reasonably available or is unable or unwilling to act as my agent, then I appoint the following persons (each to act alone and successively, in the order named), to serve in that capacity: (Optional)

A. Name: ___________________________
Home Address: ______________________
Home Telephone Number ________Work Telephone Number________

B. Name: ___________________________
Home Address: ______________________
Home Telephone Number ________Work Telephone Number________

Each successor health care agent designated shall be vested with the same power and duties as if originally named as my health care agent.

2. Effectiveness of appointment.

(Notice: This health care power of attorney may be revoked by you at any time in any manner by which you are able to communicate your intent to revoke to your health care agent and your attending physician.)

Absent revocation, the authority granted in this document shall become effective when and if the physician or physicians designated below determine that I lack sufficient understanding or capacity to make or communicate decisions relating to my health care and will continue in effect during my incapacity, until my ~~death.~~death, except if I authorize my health care agent to exercise my rights with respect to anatomical gifts, autopsy, or disposition of my remains, this authority will continue after my death to the extent necessary to exercise the authority granted in this document for these purposes.

This determination shall be made by the following physician or physicians. For decisions related to mental health treatment, this determination shall be made by the following physician or eligible psychologist. (You may include here a designation of your choice, including your attending physician or eligible psychologist, or any other physician or eligible psychologist. You may also name two or more physicians or eligible psychologists, if desired, both of whom must make this determination before the authority granted to the health care agent becomes effective.):

____
____
____
____

3. General statement of authority granted.

Except as indicated in section 4 below, I hereby grant to my health care agent named above full power and authority to make health care decisions, including mental health treatment decisions, on my behalf, including, but not limited to, the following:

A. To request, review, and receive any information, verbal or written, regarding my physical or mental health, including, but not limited to, medical and hospital records, and to consent to the disclosure of this information.

1 B. To employ or discharge my health care providers.
2 C. To consent to and authorize my admission to and discharge from a
3 hospital, nursing or convalescent home, or other institution.
4 D. To consent to and authorize my admission to and retention in a facility
5 for the care or treatment of mental illness.
6 E. To consent to and authorize the administration of medications for
7 mental health treatment and electroconvulsive treatment (ECT)
8 commonly referred to as "shock treatment".
9 F. To give consent for, to withdraw consent for, or to withhold consent
10 for, X ray, anesthesia, medication, surgery, and all other diagnostic and
11 treatment procedures ordered by or under the authorization of a
12 licensed physician, dentist, or podiatrist. This authorization
13 specifically includes the power to consent to measures for relief of
14 pain.
15 G. To authorize the withholding or withdrawal of life-sustaining
16 procedures when and if my physician determines that I am terminally
17 ill, permanently in a coma, suffer severe dementia, or am in a
18 persistent vegetative state. Life-sustaining procedures are those forms
19 of medical care that only serve to artificially prolong the dying process
20 and may include mechanical ventilation, dialysis, antibiotics, artificial
21 nutrition and hydration, and other forms of medical treatment which
22 sustain, restore or supplant vital bodily functions. Life-sustaining
23 procedures do not include care necessary to provide comfort or
24 alleviate pain.
25 I DESIRE THAT MY LIFE NOT BE PROLONGED BY
26 LIFE-SUSTAINING PROCEDURES IF I AM TERMINALLY
27 ILL, PERMANENTLY IN A COMA, SUFFER SEVERE
28 DEMENTIA, OR AM IN A PERSISTENT VEGETATIVE
29 STATE.
30 H. To exercise any right I may have to make a disposition of any part or
31 all of my body for medical purposes, to donate my organs, to authorize
32 an autopsy, and to direct the disposition of my remains.
33 I. To take any lawful actions that may be necessary to carry out these
34 decisions, including the granting of releases of liability to medical
35 providers.
36 4. Special provisions and limitations.
37 (Notice: The above grant of power is intended to be as broad as possible so that your
38 health care agent will have authority to make any decisions you could make to obtain or
39 terminate any type of health care. If you wish to limit the scope of your health care
40 agent's powers, you may do so in this section.)
41 A. In exercising the authority to make health care decisions on my behalf,
42 the authority of my health care agent is subject to the following special
43 provisions and limitations (Here you may include any specific
44 limitations you deem appropriate such as: your own definition of when

life-sustaining treatment should be withheld or discontinued, or instructions to refuse any specific types of treatment that are inconsistent with your religious beliefs, or unacceptable to you for any other reason.):

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____
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B. In exercising the authority to make mental health decisions on my behalf, the authority of my health care agent is subject to the following special provisions and limitations. (Here you may include any specific limitations you deem appropriate such as: limiting the grant of authority to make only mental health treatment decisions, your own instructions regarding the administration or withholding of psychotropic medications and electroconvulsive treatment (ECT), instructions regarding your admission to and retention in a health care facility for mental health treatment, or instructions to refuse any specific types of treatment that are unacceptable to you):

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C. (Notice: This health care power of attorney may incorporate or be combined with an advance instruction for mental health treatment, executed in accordance with Part 2 of Article 3 of Chapter 122C of the General Statutes, which you may use to state your instructions regarding mental health treatment in the event you lack sufficient understanding or capacity to make or communicate mental health treatment decisions. Because your health care agent's decisions about decisions must be consistent with any statements you have expressed in an advance instruction, you should indicate here whether you have executed an advance instruction for mental health treatment.):

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5. Guardianship provision.

If it becomes necessary for a court to appoint a guardian of my person, I nominate my health care agent acting under this document to be the guardian of my person, to serve without bond or security. The guardian shall act consistently with G.S. 35A-1201(a)(5).

6. Reliance of third parties on health care agent.

A. No person who relies in good faith upon the authority of or any representations by my health care agent shall be liable to me, my

1 estate, my heirs, successors, assigns, or personal representatives, for
2 actions or omissions by my health care agent.
3 B. The powers conferred on my health care agent by this document may
4 be exercised by my health care agent alone, and my health care agent's
5 signature or act under the authority granted in this document may be
6 accepted by persons as fully authorized by me and with the same force
7 and effect as if I were personally present, competent, and acting on my
8 own behalf. All acts performed in good faith by my health care agent
9 pursuant to this power of attorney are done with my consent and shall
10 have the same validity and effect as if I were present and exercised the
11 powers myself, and shall inure to the benefit of and bind me, my
12 estate, my heirs, successors, assigns, and personal representatives. The
13 authority of my health care agent pursuant to this power of attorney
14 shall be superior to and binding upon my family, relatives, friends, and
15 others.
16 7. Miscellaneous provisions.
17 A. I revoke any prior health care power of attorney.
18 B. My health care agent shall be entitled to sign, execute, deliver, and
19 acknowledge any contract or other document that may be necessary,
20 desirable, convenient, or proper in order to exercise and carry out any
21 of the powers described in this document and to incur reasonable costs
22 on my behalf incident to the exercise of these powers; provided,
23 however, that except as shall be necessary in order to exercise the
24 powers described in this document relating to my health care, my
25 health care agent shall not have any authority over my property or
26 financial affairs.
27 C. My health care agent and my health care agent's estate, heirs,
28 successors, and assigns are hereby released and forever discharged by
29 me, my estate, my heirs, successors, and assigns and personal
30 representatives from all liability and from all claims or demands of all
31 kinds arising out of the acts or omissions of my health care agent
32 pursuant to this document, except for willful misconduct or gross
33 negligence.
34 D. No act or omission of my health care agent, or of any other person,
35 institution, or facility acting in good faith in reliance on the authority
36 of my health care agent pursuant to this health care power of attorney
37 shall be considered suicide, nor the cause of my death for any civil or
38 criminal purposes, nor shall it be considered unprofessional conduct or
39 as lack of professional competence. Any person, institution, or facility
40 against whom criminal or civil liability is asserted because of conduct
41 authorized by this health care power of attorney may interpose this
42 document as a defense.
43 8. Signature of principal.

By signing here, I indicate that I am mentally alert and competent, fully informed as to the contents of this document, and understand the full import of this grant of powers to my health care agent.

____________________ (SEAL) ______________________
Signature of Principal Date

9. Signatures of Witnesses.

I hereby state that the Principal, __________, being of sound mind, signed the foregoing health care power of attorney in my presence, and that I am not related to the principal by blood or marriage, and I would not be entitled to any portion of the estate of the principal under any existing will or codicil of the principal or as an heir under the Intestate Succession Act, if the principal died on this date without a will. I also state that I am not the principal's attending physician, nor an employee of the principal's attending physician, nor an employee of the health facility in which the principal is a patient, nor an employee of a nursing home or any group care home where the principal resides. I further state that I do not have any claim against the principal.

Witness: ____________________ Date: __________

Witness: ____________________ Date: __________

STATE OF NORTH CAROLINA

COUNTY OF____________________

CERTIFICATE

I, __________, a Notary Public for _________ County, North Carolina, hereby certify that __________ appeared before me and swore to me and to the witnesses in my presence that this instrument is a health care power of attorney, and that he/she willingly and voluntarily made and executed it as his/her free act and deed for the purposes expressed in it.

I further certify that _________ and ________, witnesses, appeared before me and swore that they witnessed ________ sign the attached health care power of attorney, believing him/her to be of sound mind; and also swore that at the time they witnessed the signing (i) they were not related within the third degree to him/her or his/her spouse, and (ii) they did not know nor have a reasonable expectation that they would be entitled to any portion of his/her estate upon his/her death under any will or codicil thereto then existing or under the Intestate Succession Act as it provided at that time, and (iii) they were not a physician attending him/her, nor an employee of an attending physician, nor an employee of a health facility in which he/she was a patient, nor an employee of a nursing home or any group-care home in which he/she resided, and (iv) they did not have a claim against him/her. I further certify that I am satisfied as to the genuineness and due execution of the instrument.

1 This the ___________ day of _____________, ____
2
3 ______________________________
4 Notary Public
5
6 My Commission Expires:
7 _________________________
8
9 (A copy of this form should be given to your health care agent and any alternate
10 named in this power of attorney, and to your physician and family members.)"
11 **SECTION 4.** This act is effective when it becomes law.