

## Form Instructions

1. There are numerous types of advance directives. Parkview Health encourages you to talk to your doctors, health care team, family and your attorney when completing any advance directive.
2. This state form is not required for an appointment of a health care representative. An individual may use a form designed by their attorney or other entity to specifically meet the individual's needs. To be valid, any form must comply with statutory requirements.
3. An individual is not required to complete a health care representative appointment form. An individual may always choose to not appoint a health care representative. If there is no appointed representative, state medical consent laws would determine who may consent to your health care.
4. The medical record number and health care facility or provider is not required for the appointment to be effective. It may be included as a means of assisting the health care provider in identifying the correct patient and locating the appointment in the correct medical record.
5. The patient/appointor may specify in the appointment appropriate terms and conditions, including an authorization to the representative to delegate the authority to consent to another.
6. The authority granted becomes effective according to the terms of the appointment.
7. The appointment does not commence until the appointor becomes incapable of consenting. The authority granted in the appointment is not effective if the patient/appointor regains the capacity to consent.
8. Unless the appointment provides otherwise, a representative appointed under this section who is reasonably available and willing to act has priority to act in all matters of health care for the patient/appointor, except when the patient/appointor is capable of consenting.
9. The appointment of a health care representative must be witnessed by an adult other than the health care representative.
10. In making all decisions regarding the patient's/appointor's health care, the health care representative shall act:
  - a. In the best interest of the patient/appointor consistent with the purpose expressed in the appointment.
  - b. In good faith.
11. A health care representative who resigns or is unwilling to comply with the written appointment may not exercise further power under the appointment and shall so inform the following:
  - a. The patient/appointor.
  - b. The patient's/appointor's legal representative if one is known.
  - c. The health care provider if the representative knows there is one.
12. An individual who is capable of consenting to health care may revoke:
  - a. The appointment at any time by notifying the representative orally or in writing; or
  - b. The authority granted to the representative by notifying the health care provider orally or in writing.

**For more information,  
please visit the following websites:**

[www.parkview.com](http://www.parkview.com)

[www.in.gov/isdh/25880.htm](http://www.in.gov/isdh/25880.htm)

# ADVANCE DIRECTIVE

## Appointment of a Health Care Representative

*This brochure introduces laws that affect advance directives for health care in Indiana. It provides information about a health care representative appointment. It is not intended to substitute for estate planning with an attorney, nor is it a substitute for professional legal advice. Statements reflect legislation in effect in Indiana as of June 1, 2017. Other states have different laws; some information may not apply outside of Indiana.*



## INDIANA HEALTH CARE REPRESENTATIVE APPOINTMENT

State Form 56184 (11-16)  
Indiana State Department of Health – IC 16-36-1; IC 16-36-6

**INSTRUCTIONS:** See *instructions on back*.

<b>Patient / Appointor Information</b>			
Patient Last Name	Patient First Name	Patient Middle Initial	
Patient Birthday (mm/dd/yyyy)	Medical Record Number of Healthcare Facility or Provider (optional)	Healthcare Facility or Provider (optional)	
<b>Appointment of Health Care Representative</b>			
<p>I, being at least eighteen (18) years of age, of sound mind, and capable of consenting to my health care, hereby appoint the person(s) named below as my lawful health care representative in all matters affecting my health care, including but not limited to providing consent or refusing to provide consent to medical care, surgery, and/or placement in health care facilities, including extended care facilities, unless otherwise provided in this appointment. This appointment shall become effective at such time and from time to time as my attending physician determines that I am incapable of consenting to my health care. I understand that if I have previously named a health care representative the designation below supersedes (replaces) any prior named Health Care Representative(s).</p> <p>I authorize my health care representative to make decisions in my best interest concerning withdrawal or withholding of health care. If at any time based on my previously expressed preferences and the diagnosis and prognosis my health care representative is satisfied that certain health care is not or would not be beneficial or that such health care is or would be excessively burdensome, then my health care representative may express my will that such health care be withheld or withdrawn and may consent on my behalf that any or all health care be discontinued or not instituted, even if death may result. My health care representative must try to discuss this decision with me. However, if I am unable to communicate, my health care representative may make such a decision for me, after consultation with my physician or physicians and other relevant health care givers. To the extent appropriate, my health care representative may also discuss this decision with my family and others to the extent they are available.</p> <p>I specify the following terms and conditions (if any):</p>			
Name of Representative Appointed	Address of Representative (number and street, city, state, and ZIP code)	Telephone Number of Representative	
Signature of Patient / Appointor or Designee (must be signed in the appointor's presence)	Printed Name of Patient / Appointor or Designee	Date of Appointment (mm/dd/yyyy)	
Signature of Witness	Printed Name of Witness	Date (mm/dd/yyyy)	



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