Instructions for Completing and Signing
Living Will & HIPAA Release Authorization

LIVING WILL (starts on page 1) – A Living Will Declaration is designed to document your intention that you want life-sustaining treatment, including artificial nutrition and hydration, to be withheld or withdrawn if you are permanently unconscious or terminally ill, and two physicians have determined your health will not improve. Under Ohio law, a Living Will Declaration is only applicable to individuals in a permanently unconscious state or a terminally ill condition.

Page 2

In the first blank, please print your full name, as it appears on your driver's license.

In the blank space on the second row, you need to print your date of birth.

Page 4

You will check the box marked "Yes" if you also have a Health Care Power of Attorney (or "No" if you do not).

The blank lines in the middle of the page are for you to fill in the contact information of the persons you want physician to make reasonable effort to notify if you are in a permanently unconscious or terminally ill state, and that the physician will be withdrawing life-sustaining treatment.

Page 5

Place your initials in the *Special Instructions* box—this is your declaration to your physician that you want artificial nutrition and hydration withdrawn if you are in a permanently unconscious or terminally ill condition.

If you have any additional instructions for your physician, include them in the box at the bottom of the page (if you have no additional instructions, write "None" in the box.

Page 6

If you would like to make an anatomical gift upon your gift, check the appropriate boxes at the top of the page.

At the bottom of page six, write in the current date and city in which you are signing, and sign your name on the *Declarant* line. *

Page 7

***You must sign your name in BLUE ink either in front of two independent witnesses, or a notary public. Witnesses must provide their printed name and address.**

HIPAA RELEASE AUTHORIZATION – Pursuant to the Health Insurance Portability and Accountability Act of 1996, you may authorize your physicians to release your health records to the person you name (the "Recipient"). Per the Instructions Page, you need only complete Form A (Page 1 of 2).

Form A

In Section I, provide the information required by an asterisk (you may choose to include all of the other personal information if desired).

In Section II, provide the contact information of your physician's office, insurance company, etc. (whoever would be disclosing your health records). Also, provide the name of the Recipient of your health records.

In Section III, provide the reason you want to disclose your records, and what health information is to be shared.

In Section IV, provide an expiration date for this HIPAA Release. Per the form, if no date is specified the authorization will expire in one year.

Sign your name and include the date at the bottom of the page.