7. MEDICAL RECORDS REQUIREMENTS

A. PCP and IPA Medical Record Requirements

APPLIES TO:

A. This policy applies to all IEHP Medicare DualChoice (HMO SNP) and IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan) Members.

POLICY:

A. IEHP and/or the IPA (if delegated) are responsible for establishing medical record standards in the IEHP Provider Policy and Procedure Manual and promulgating these to Providers and PCPs.
B. All Providers and practitioner offices must maintain policies and procedures consistent with IEHP standards, state and federal laws and regulations for maintenance of Member medical records.
C. IEHP and/or the IPA (if delegated) performs PCP Site Review and Medical Record Review Surveys prior to site participation.
D. A Medical Record Review is performed at the time of the Site Review if medical records are available; otherwise, Medical Record Review is performed within 90-180 days of the practitioner’s effective date with IEHP.

PROCEDURE:

IEHP Medical Records Standards

A. Individual Medical Records – An individual medical record is created for each Member treated by an IEHP practitioner. The medical record is designed to maintain a Member’s documented medical information of the care provided, as well as all ancillary services/diagnostic tests ordered by a practitioner and all referred diagnostic and therapeutic services in a consistent, logical, and uniform manner. The same medical record may be used by other treating practitioners within the same group in order to provide conformity and coordination of Member care. This unique medical record must be updated by the practitioner or office staff with each Member visit or contact. Detailed behavioral health and substance abuse records may be filed separately to maintain confidentiality.

B. Member Identification – Members should be linked to their individual medical records through an assigned unique identifier for filing purposes and to distinguish that record from any other Member record. Each page, test result, letter, and item of correspondence regarding that individual Member must contain the unique identifier, and Member (patient) name as a means of Member identification.

C. Member Demographics – Each medical record must contain a section for Member identification that includes name, age, employer, occupation, work and home telephone numbers, address, insurance information, marital status and emergency contact person
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information.

D. Responsible Party – Physicians designate individuals responsible for record maintenance. Responsible parties must follow established protocols for the daily collection, research, retrieval, securing, maintaining, and transporting of medical records within the physician setting.

E. Legal Document – The medical record is a legal document and all contents must be maintained in a confidential manner.

F. Medical Record Maintenance – The Member medical record must be maintained in a current and detailed organized manner that reflects effective care of the Member and also facilitates quality review.

G. Protection and Confidentiality – Physicians must limit medical records access to authorized practitioners and associated staff. Records are maintained in a protective and confidential manner and are not readily accessible to unauthorized persons or visible to the general public. Practitioners and Providers must maintain policies and procedures to ensure appropriate record processing to prevent breach of protection or confidentiality or the unauthorized release of Member information to any internal or external person. Practitioners and providers must educate staff regarding confidentiality and records maintenance policies and procedures and ensure that confidentiality statements are signed. A copy of the IEHP Medical Record policies must be available at each physician office as addressed in Policy 7B, “Information Disclosure and Confidentiality of Medical Records.”

H. Storage, Filing and Availability – Physicians must maintain an organized record-keeping system to make the individual medical record available for each Member visit or contact including: collection, processing, maintenance, storage, retrieval, identification, and distribution. Records must be stored in a secured location either in the Physician’s office or in a central file area that is inaccessible to unauthorized persons. Physicians must maintain procedures to assign the unique identifier to each individual record and ensure that the appropriate record is pulled for each Member. Filing of records must be done in a consistent manner either alphabetically or by Member identifier number. Physicians must have written procedures for the disposition of medical records including designation of the person or persons responsible for record maintenance. In addition, procedures must outline the methodology for pulling requested records, methodology for tracking, the amount of notification time required, and system of distribution and collection. Physicians must have provisions for obtaining medical records on an emergency basis. Medical records are to be kept in a clean, secure environment and in good condition.

I. Record Retention – Physicians must retain medical records pertaining to Members for a period of ten (10) years from the end of the fiscal year in which IEHP’s contract expires or is terminated. Pediatric medical records must be maintained for a minimum of ten (10) years or until the Member’s 19th birthday, but in no event for less than 10 years. All
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medical records, medical charts and prescription files, and other documentation pertaining to medical and non-medical services rendered to Members are subject to this requirement.

J. Informed Consent for Treatment – Practitioners must obtain appropriate written consent for treatment prior to actual procedure performance including the human sterilization consent procedures. Consent forms must be completely filled out to include risk, benefits and alternative treatments, signed in ink, and retained in the Member’s medical records. If someone other than the Member signs the consent, the legal relationship should be noted on the consent form. Practitioner staff must witness, sign, and date consent forms. Practitioners must not require a Member, as a condition of receiving health care services, to sign a consent that would permit the disclosure of medical information. Refer to Policy 7C, “Informed Consent” for more information.

K. Release of Information – Medical records contain confidential information that is not to be released to another party outside of the practitioner without the expressed consent, written in ink, of the Member or legal representative. Practitioners must maintain procedures for obtaining such written consent prior to release of copied records. The consent should be filed in the Member’s medical record and include the date copies were mailed or released, name of receiving or requesting party, a list of the copied portion of the medical record including behavioral health information, if applicable, the information being requested, the purpose for the request, and the length of time the information is kept (for behavioral health services only). Member medical records must be made available to authorized reviewers per applicable state laws and regulations. Section 123110 of the Health & Safety Code states that any adult patient, or any minor patient who by law can consent to medical treatment is entitled to inspect patient records upon written request within five (5) working days after receipt of the written request. Members are also entitled to copies of all or any portion of his or her records upon written request. Physicians must provide Members with copies within fifteen (15) days of the receipt. Physicians receiving medical records request from other Medical Providers must submit the medical records within 15 days of receiving the written request to avoid any delay in the Members care. Refer to Policy 7B, “Information Disclosure and Confidentiality of Medical Records” for more information.

The State has determined that a managed Medicare DualChoice Member can never be charged for any covered services. As it is customary for physicians not to charge, IEHP encourages our practitioners to offer this as a complimentary service to other physicians. When absolutely necessary to charge another physician, the law allows only $.25 per page and to limit a total charge to $20.

L. Legibility and Maintenance – Practitioners must establish a uniform format to organize medical records and maintain all medical records in a consistent and comprehensive manner. Medical record entries are to be legible, made in a timely manner, dated, and signed by the appropriate practitioner or staff. Records are usually maintained in hard copy format, however, they may be maintained electronically as long as they are easily...
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accessible, have sufficient backup to prevent loss of information and have a unique electronic identifier for the author. The medical record must be legible to someone other than the author.

M. Exam Information - Each medical record entry must contain all pertinent information related to the Member contact including complaints, symptoms, examination results, medical impressions, treatments, Member condition, test results, and proposed follow-up. A SOAP format may be used to satisfy this requirement.

N. Medical Record Contents – Physicians must maintain a complete and comprehensive medical record for each Member. The record must include all Provider services rendered including examinations, Member contacts, health maintenance or preventive services, laboratory and radiology test results or reports, procedures, ancillary services, off-site treatments, Emergency Room records, and hospital admission and discharge information. Correspondence regarding the Member’s medical condition, such as consultation records, specialist reports, and referrals, must also be included in the Member record. Pathology and laboratory/radiology reports are included in the record with a special notation for all abnormal findings. Each page, insert, test, and lab entry must identify by Member name and Member identifier. The medical record must include Member identification, biographical data, emergency contact information, and informed consents.

O. Documentation Standards – IEHP documentation standards and goals for medical record maintenance are as follows:

1. Each page in the record contains the Member’s name or identification number.
2. Medication allergies and adverse reactions are noted in a consistent, prominent place. Otherwise, no known allergies or history of adverse reactions is noted.
3. Past medical history for Members seen more than three times is documented. This documentation includes serious accidents, operations and childhood illnesses. For children and adolescents (20.99 years and younger), past medical history relates to prenatal care, birth, operations and childhood illnesses.
4. The use of cigarettes, alcohol and history of substance abuse noted for Members age 12 and older (substance abuse history is queried for Members seen three or more times).
5. Problem lists are maintained for Members with significant illnesses and/or conditions that are monitored. A chief complaint and diagnosis or probable diagnosis is included.
6. The history and physical examination records must include appropriate subjective and objective information pertinent to the Member’s presenting complaints.
7. Documentation of exams are appropriate for the medical condition.
8. All medications prescribed include the name, dosage, frequency, and route unless medication only comes in oral form.
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9. Medications given on-site list name, dosage, and route as well as the site given, manufacturer’s name and lot number and whether the Member had a reaction to the medication.

10. Laboratory and other studies are ordered and documented, as appropriate.

11. All treatments, procedures, and tests, with results, are documented.

12. Working diagnoses are consistent with findings.

13. Treatment plans are consistent with diagnoses.

14. Notes have a notation, when indicated, regarding needed follow-up care, calls or visits. The specific time of return is noted in weeks, months, or as needed.

15. Unresolved problems from previous office visits are addressed in subsequent visits.

16. Member education, recommendation and instructions given are included.

17. Pediatric Members’ (age 20.99 and under) records have a completed immunization record or notation of immunizations up to date.

18. An immunization history has been noted for adults.

19. There is no evidence that the Member is placed at inappropriate risk by a diagnosis or therapeutic procedure.

20. Preventive screening and services are offered and documented in accordance with IEHP standards.

21. Referrals for specialty care or testing are noted, when appropriate.

22. Consultant notes are present, as applicable.

23. Consultation, lab and imaging reports filed in the chart are initialed by the practitioner who ordered them to signify they have been reviewed. Review and signature by professionals other than the ordering practitioner do not meet this requirement. If the reports are presented electronically or by some other method, there is also representation of review by the ordering practitioner. Consultation, abnormal lab and imaging study results have an explicit notation in the record of follow-up plans.

24. For ages 18 years and older, as well as Emancipated Minors, documentation of Advance Directives discussion is present.

P. **Completeness of the Medical Record** – The medical record must be checked to assure that all ordered procedure and referral notes are returned and filed in the chart within three working days of the visit, procedure, or receipt of the report/progress notes from any outside practitioner into the physician office. The practitioner must review and initial all test results and consultations and document follow-up treatment for abnormal lab results.
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Q. **Laboratory and Radiology Results** – Practitioners must maintain procedures for filing laboratory and radiology results in the Member’s medical record. STAT tests are to be performed and reported within twenty-four (24) hours. Physicians must have procedures for review of test results, notation of normal and abnormal results in the medical record, and documentation of instructions for follow-up. Practitioners must have guidelines identifying which staff member is authorized to notify Members of test results. Tests performed by the practitioner or associated office staff must have results documented in the medical record.

R. **Language Preference** – Each medical record include a designation of primary language and documentation of request or refusal of language interpretation services. Practitioner documentation must be in English.

S. **Physician and Staff Entries and Signatures** – Each entry including chief complaint and vital signs or Member contact, including telephone conversation/advice noted in a Members medical record must be dated and signed by the practitioner and/or ancillary staff, if applicable, including the title of the person making the chart entry. This includes all therapies, procedures, and medications administered to a Member. When documentation errors occur, the person that makes the error must correct the error in the following manner:

1. A single line is drawn through the error;
2. The corrected information is written as a separate entry and includes the following:
   a. date of the entry;
   b. signature (or initials); and
   c. title.
3. There are to be no unexplained cross-outs, erased entries or use of correction fluid. Both the original entry and corrected entry are to be clearly preserved. One method used for correcting documentation errors is the S.L.I.D. Rule: Single Line, Initial and Date.

T. **Follow-Up Care Documentation** – Specific follow-up care instructions and a definite time for return visit or other follow-up care is appropriately documented in the Members medical record. The time period for return visit or other follow-up care is definitively stated in number of days, weeks, months or PRN.

U. **Advance Directives** – Adult medical records that contain information regarding execution of advance directives such as a living will or Durable Power of Attorney for Health Care, for Members 18 years or older, as well as Emancipated Minors, must be prominently noted. Refer to Policy 7D, “Durable Power of Attorney for Health Care” for more information.

V. **Initial Preventive Physical Exam** – PCPs must have a system to notify Members of the
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need for an initial preventive physical exam (IPPE) within 12 months of enrollment to assess current medical condition, institute any necessary treatments, and outline preventive health care programs. This offers the Member and PCP an opportunity to discuss medical concerns and establish a baseline for future care. The initial preventive health screening includes a comprehensive history and physical exam, and any referrals to health education services. Specific notations must be made concerning use of cigarettes, alcohol, and substance abuse for Members age 12 or older. Included with the notation should be health education or counseling regarding such use.

W. Follow-up Care for Referrals, Emergency Treatment, Hospitalization, Home Health Care, Skilled Nursing Facility (SNF) or Surgical Treatment Rendered at Surgical Center – The medical record must reflect continuity of care for any treatment, emergency or otherwise, rendered in a hospital, emergency room, urgent care, home health, SNF, or surgical center setting. Documentation must include the provisions for follow-up or continued treatment. PCPs must document referrals to specialists or waiver programs, treatments rendered or recommendations made and follow-up care to be instituted.

Monitoring

A. Audit Scope – The Medical Record Review Survey process is focused on PCPs, PCP/OBs and OB specialists. Medical record reviews for any other contracted physicians and specialty care practitioners are conducted as directed by the IEHP Chief Medical Officer or Quality Management (QM) Committee.

B. Audit Frequency - IEHP conducts a Medical Record Review Survey for PCPs at the time of the Initial Site Review Survey, when records are available or within 90 days of the PCP effective date after the initial review. An additional extension of 90 calendar days may be allowed only if the new provider does not have sufficient Member assignment to complete a review of ten (10) medical records. If there are still fewer than ten (10) assigned Members at the end of six (6) months, a medical record review is completed on the total number of records available or on a sample chart and the scoring adjusted according to the number of records received. The Medical Record Review Survey evaluates compliance with IEHP Policies and Procedures and is conducted every three (3) years. Refer to Policy 6A, “Site Review and Medical Records Review Requirements and Monitoring,” for more information.

C. Medical Record Information – The information in the medical record is evaluated and performance improvement actions required as necessary to ensure that the documentation is current, detailed, and organized and that it shows sound professional practice and appropriate preventive health education and referral.

D. Medical Records Systems – Medical record systems for PCPs are evaluated for adequacy and appropriateness by IEHP during the Site Review Surveys. The Medical Record Review Survey is utilized to gather information necessary to evaluate PCP and organization-wide compliance with IEHP approved medical record standards.
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E. **Maintenance of Medical Record Policy** - Each contracting provider and practitioner is responsible for maintaining medical record policies and procedures in compliance with IEHP, regulatory, and NCQA requirements.

F. **Audit Tool Requirements** - The audit tool for Medical Record Review Survey used by IEHP includes elements from regulatory agencies under the direction and approval of the QM Committee. Practitioner compliance with medical record standards must meet IEHP and regulatory requirements.

G. **Audit Process:**

1. Organization-wide compliance is evaluated during annual medical record study.

2. Data is compiled and analysis is presented to the QM Committee for recommendations regarding follow-up actions.

3. Practitioner specific and/or organization-wide CAPs are developed as appropriate and implemented.

4. Follow-up evaluations are conducted as needed to determine the effectiveness of the CAP.

5. Data may be compared with quality indicators for outcome management as indicated.

H. **Medical Record Review Survey** – The number of medical records reviewed depends on the type and status of the practitioner. This information is detailed in the following table:

<table>
<thead>
<tr>
<th>GP, IM seeing Members ages 21+</th>
<th>10 Adult Records</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinic/Staff Model Setting and Residency Teaching Clinics (Patient care by multiple PCPs)</td>
<td></td>
</tr>
<tr>
<td>One to Three PCPs</td>
<td>10 Records</td>
</tr>
<tr>
<td>Four to Six PCPs</td>
<td>20 Records</td>
</tr>
<tr>
<td>Seven or More PCPs</td>
<td>30 Records</td>
</tr>
<tr>
<td>CAP Verification</td>
<td>5 Medical Records</td>
</tr>
</tbody>
</table>

**Medical Record Review Surveys are used to assess the following (when applicable):**

**All Records:**

1. Format;

2. Documentation; and

3. Coordination /Continuity of Care.
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Adults:
1. Initial Preventive Physical Exam (IPPE);
2. Periodic Health Evaluation;
3. Tuberculosis Screening;
4. Blood Pressure;
5. Obesity screening;
6. Cholesterol;
7. Chlamydia Screening;
8. Mammogram;
9. Pap Smear;
10. Colorectal screening; and
11. Adult Immunizations.

I. Monitoring Results – IEHP systematically monitors all PCP sites between each regularly scheduled Site and Medical Record Review Survey. Monitoring sites between audits shall include the use of both internal quality management systems and external sources of information. See Policy 6A, “Site Review and Medical Record Review Survey Requirements and Monitoring.”

J. PCP sites that are removed from participation in the IEHP network due to failure of a site review and medical record review survey may appeal to IEHP for reconsideration in accordance with Policy 6C, “PCP Sites Denied Participation or Removed from the IEHP Network.”
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B. Information Disclosure and Confidentiality of Medical Records

APPLIES TO:

A. This policy applies to all IEHP Medicare DualChoice (HMO SNP) and IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan) Members.

POLICY:

A. Providers must fully comply with all applicable sections of the Health Insurance Portability and Accountability Act (“HIPAA”), the California Civil Code, Section 56 et seq., the Confidentiality of Medical Information Act; Health and Safety Code Section 1364.5; the Insurance Information and Privacy Protection Act, Code 791, et. seq.; and all other applicable State, Federal and local regulations pertaining to confidentiality, privacy and information disclosure of medical records.

B. Providers and behavioral health practitioners must fully comply with Sections of the Civil Code and Sections of HIPAA that prohibit health care practitioners from releasing specified medical information unless the person or treating entity requesting the information submits a written request signed by the Member or his/her legal representative/guardian.

1. California Civil Code, Section 56.104 - Prohibits the release of specified medical information created regarding an individual as a result of that person’s participation in outpatient behavioral health.

2. California Civil Code, Section 56.17 - Prohibits the release of specified medical information created regarding genetic testing of an individual.

3. 45 CFR Section 164.508 – Prohibits a covered entity from disclosing a Member’s Protected Health Information (PHI) without a Member’s authorization unless the disclosure is for treatment, payment, or health care operations.

C. IEHP is responsible for establishing standards for the protection and maintenance of Member medical records. IEHP medical record standards and any updates are distributed at least annually to contracted Providers and PCPs.

D. Providers and network practitioners are required to maintain Member medical records in a manner that is compliant with IEHP standards.

E. IPAs are responsible for monitoring network practitioners for compliance with IEHP medical record standards. Physician offices are required to maintain policies and procedures consistent with IEHP requirements.

F. Providers and behavioral health practitioners are responsible for ensuring that network practitioners do not release specified medical information regarding the Member’s participation in outpatient behavioral health programs without appropriate Member consent and without a written request signed by the requestor as specified in Civil Code.
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Section 56.104 and 45 CFR Section 164.508. For more information on release of behavioral health information, please see the ‘Behavioral Health Information’ section in this Policy.

G. Contracted Providers and Practitioners must disclose medical information when the information is requested by a coroner in the course of an investigation.

H. Contracted Providers and Practitioners who create, maintain, preserve, store, transmit or destroy medical records must do so in a manner that preserves the confidentiality of the information contained in the records.

PROCEDURE:

Confidentiality of Medical Records

A. Providers are responsible for orienting all practitioner’s office staff, practitioners and committee members to IEHP policies and procedures regarding confidentiality of Member medical records including:

1. The maintenance of confidentiality of Member medical records used comprehensively by the practitioner;
2. The protection of medical record information including the documentation used in utilization and case management processes; and
3. The protection of medical record information used in the claims process.

B. Providers are responsible for maintaining signed confidentiality statements as follows:

1. Providers and office staff are required to sign a confidentiality statement protecting the privacy of Member medical records and information;
2. IPA committee members and all other attendees of IPA committee meetings are required to sign a Member medical record confidentiality statement; and
3. Providers must have policies and procedures in place that require practitioners and other subcontractors to maintain confidentiality that includes signed confidentiality statements as applicable.

C. Upon request, Providers and Practitioners must disclose Members’ confidential medical information to governmental regulators, or other legal authorities for purposes of:

1. Administering benefits under the Medicare program, including determination of responsibility for payment, Member’s eligibility for benefits, provision of services to eligible recipients and payment of claims;
2. Coordination of care between practitioners as necessary;
3. Professional peer review or utilization review and quality management (as
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4. Conducting actuarial or research studies; and

5. Providers and practitioners may not disclose medical information related to a Member’s participation in behavioral health treatment unless the requirements delineated in the ‘Behavioral Health Information’ section of this Policy have been met.

D. Upon request, Providers and practitioners must disclose Member medical information to independent medical review organizations and their reviewers without specific authorization by the Member. Independent medical review organizations may include public or private licensing or accrediting entities such as the DMHC or its contractors.

E. Members have the right to inspect or correct any personal or medical information held by their medical practitioner.

F. Members have the right to develop a written addendum for inclusion in their medical record if they believe that the records are incomplete or inaccurate. Practitioners must include this addendum as a permanent part of the Member’s medical record and must disclose it to other parties when records are requested.

G. Members have the right to request an accounting of disclosures of protected health information made by the covered entity for the six (6) years.

H. Any dissemination of Member information for actuarial or research purposes should not specifically identify any particular Member.

I. Private Health Information (PHI) that is electronically transmitted to another entity must be sent in compliance with the Health Insurance Portability and Accountability Act (HIPAA) Security Rule, as required by the Health Information Technology for Economic and Clinical Health Act (HITECH Act) as part of the American Recovery and Reinvestment Act of 2009.

J. At no time shall the Providers, its staff, medical facilities, practitioners or affiliates, obtain personal or otherwise deemed confidential information under a false pretense.

Release of Medical Records

A. Providers are responsible for orienting all practitioners office staff, practitioners, and committee members to IEHP Policies and Procedures regarding the release of Member medical records including:

1. The release of medical record information at the request of the Member and in response to legal requests for information;

2. The release of a Member’s behavioral health records without the Member’s written consent, in ink; and
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B. **Information Disclosure and Confidentiality of Medical Records**

3. The release of a Member’s genetic testing records without the Member’s written consent in ink.

B. Members (or their legal guardians/representatives) must be given the opportunity to approve or deny the release of identifiable personal medical record information, including behavioral health and genetic testing, by the practitioner and practitioner’s staff, except to the extent that the law allows release of information.

C. Member medical records are kept confidential and information must be released only according to approved IEHP policy and procedure.

D. Practitioners and office staff may release medical record information only if a signed consent has been obtained from the Member, the parent or legal guardian or the person legally responsible for making medical decisions for the Member. However, 45 CFR Section 164.506 and the California Civil Code, Section 56.10, allows for the release of medical records to health plans for the purposes of:

1. Administering benefits under IEHP programs, including determination of responsibility for payment, Member’s eligibility for benefits, provision of services to eligible recipients and payment of claims;
2. Coordination of care between practitioners as necessary;
3. Professional peer review or utilization review and quality management (as established by Congress in Public Law 97-248 in 1982);
4. Conducting actuarial or research studies; and
5. Medical information regarding a Member’s participation in behavioral health treatment may not be released unless the requirements delineated in the ‘Behavioral Health Information’ section of this Policy have been met.

E. Practitioners and office staff must disclose Member medical information when the request is from a coroner, in the course of an investigation for the purpose of identifying the Member or locating next of kin. Disclosure must also be provided when the coroner’s office is investigating deaths that may involve public health concerns, organ or tissue donation, child abuse, elder abuse, suicides, poisonings, accidents, sudden infant death, suspicious deaths, unknown deaths, or criminal deaths, or when otherwise authorized by the Member’s representative. Medical information shall be limited to information regarding the patient who is the Member and who is the subject of the investigation. This information must be given to the coroner without delay.

F. Except to the extent permitted by law, and notwithstanding a Member’s legal or court appointed representative, confidential information pertaining to a Member’s medical records must not be released to family members, unless written authorization is on file. The authorization must allow for release of information to family members, or a court
7. MEDICAL RECORDS REQUIREMENTS

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document must be presented that substantiates the family member’s right to obtain confidential medical record information on the Member.

G. Questions regarding release of medical information to insurance carriers and other healthcare practitioners and staff must be directed to the practitioner.

H. Subpoenas are handled according to the IPA’s policies and procedures and in accordance with state and federal regulatory requirements.

I. Any person making copies of Member medical record information must note the release in the departmental, medical, or computer record, sign and date the entry, and document what information was copied.

J. Written authorization for the release of health information must meet the following criteria, as delineated in California Civil Code Section 56.11 and 45 CFR Section 164.508:

1. Is hand written in plain language by the person who signs it or is in typeface no smaller than 14-point type;

2. Is clearly separate from any other language on the same page and is executed by a signature which serves no other purpose than to execute the authorization;

3. Is dated and signed by the Member, the Member’s legal representative, the Member’s spouse or person financially responsible for the Member, or the beneficiary or personal representative of a deceased Member;

4. Specifies the uses and limitations on the types of medical information to be disclosed;

5. Specifies the names or functions of persons authorized to disclose the information about the Member;

6. Specifies the names or functions of persons authorized to receive the disclosed information;

7. Specifies the specific uses and limitations for persons receiving the information;

8. Specifies a specific date after which the authorization is no longer valid;

9. If a covered entity seeks an authorization, the covered entity must provide the Member with a copy of the authorization they signed;

10. The authorization must include the Member’s individual right to revoke the authorization in writing; and

11. An authorization revocation is allowed at any time as long as the covered entity has not taken action in reliance of that authorization.

K. Should the requesting party need an extension to the timeframe mentioned above, they must notify the practitioner in writing. This information should include:
7. MEDICAL RECORDS REQUIREMENTS

B. Information Disclosure and Confidentiality of Medical Records

1. The specific reason for the extension;
2. The intended use or uses of information during the extended time; and
3. The expected destruction date of the information.

L. Upon request, all Providers are required to make available to Members the Provider’s policy of Information Disclosure and Confidentiality of Medical Records.

M. IEHP makes available to its Members its policies and procedures for preserving the confidentiality of medical records. Any request for IEHP’s policy of Information Disclosure and Confidentiality of Medical Records must be directed to IEHP Member Services at (800) 440-4347.

N. Providers must fully comply with all applicable sections of the “HIPAA” Insurance Information and Privacy Protection Act (“The Act”), Insurance Code 791 et seq.; The Confidentiality of Medical Information Act (“CMIA”), California Civil Code 56, et seq.; the HITECH Act; and all other applicable State, Federal and local regulations pertaining to confidentiality, privacy and information disclosure of medical records.

O. Providers must develop and implement a disclosure authorization form that is compliant with California Civil Code Section 56.11, HIPAA and 45 CFR Section 164.508. An example of acceptable language is as follows:

“I, the undersigned, hereby authorize (Releasing Entity) to release to (Receiving Entity), any and all medical records pertaining to (Patient’s Name) specifically relating to (Type of Information/Date Parameters). This authorization of the medical information specified herein is to be used solely for the purpose of (Uses/Limitations) and will expire after (Date). I also understand that I have the right to receive a copy of this authorization. I also understand that I have the right to revoke this authorization in writing.”

Signed: ____________________  Date: ____________________

Print Name: ________________

Relationship to Patient: ________________

P. Providers/practitioners must not require a Member, as a condition of receiving health care services, to sign a release or consent that would permit the disclosure of medical information per Section 56.10 of the California Civil Code.
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B. Information Disclosure and Confidentiality of Medical Records

Q. Providers/practitioners are prohibited from intentional sharing, selling or using medical information for any purpose not necessary to provide health care services to the Member, except as otherwise authorized.

R. All Providers must maintain information disclosure policies that are in full compliance with the Federal Regulations of HIPAA and Section 56.10 of the California Civil Code.

S. Providers monitor practitioner sites for compliance with IEHP requirements for the protection of Member medical records.

Sensitive Services Information

A. The release of information related to sensitive services must meet the same specifications as noted in section “J” above.

B. In special circumstances for treatment of sensitive services such as sexually transmitted disease, HIV, and family planning, Members have the right to sign a Limited Release of Information Form that prohibits the release of medical records, but does allow release of sufficient information for billing purposes, as outlined in the Policy 10G, “Sexually Transmitted Disease (STD) Services.”

C. Except in cases where direct health care practitioners are disclosing the results of HIV tests for purposes directly related to the health care of the Member, all IEHP network practitioners must obtain written consent from the Member to disclose results of an HIV test.

Genetic Testing Information

A. “Genetic characteristics” as used in this section, shall be defined as follows:

1. Any scientifically or medically identifiable gene or chromosome, or combination or alteration thereof, that is known to be the cause of a disease or disorder in a person or his or her offspring, or that is determined to be associated with a statistically increased risk of development of a disease or disorder and presently not associated with any symptoms of any disease or disorder; or

2. Inherited characteristics that may derive from the individual or family member, that are known to be a cause of a disease or disorder in a person or his or her offspring, or that are determined to be associated with a statistically increased risk of development of a disease or disorder and presently not associated with any symptoms of any disease or disorder.

B. The release of information related to genetic testing must meet the same specifications as noted in section “J” above.

C. In addition, the person or entity requesting the medical record information must submit a copy of the written request to the Member within 30 days of receipt of the requested information, unless the Member has signed a written waiver in the form of a letter that is
7. MEDICAL RECORDS REQUIREMENTS

B. Information Disclosure and Confidentiality of Medical Records

submitted by the Member to the health care practitioner of IEHP waiving this notification.

D. A person who negligently or willfully discloses the results of a test for genetic characteristics to any third party is subject to those penalties described in Section 56.17 of the California Civil Code that prohibits health care practitioners from releasing specified medical information created regarding genetic testing of an individual unless the person or treating entity requesting the information submits a written request signed by the Member.

Behavioral Health Information

A. Providers and practitioners may not release medical information to persons or entities authorized to receive that information pursuant to Federal Regulations under HIPAA and California Civil Code, Section 56.104, if the requested information specifically relates to a Member’s participation in behavioral health treatment, unless the following requirements have been met:

1. The person or entity requesting that information (“requestor”) submits a written request to the practitioner or provider, whichever is applicable, signed by the requestor. The request must include:
   a. The specific information relating to a Member’s participation in behavioral health treatment and its specific use(s);
   b. A statement that the information is not to be used for any purpose other than its intended use;
   c. The length of time that the information will be kept before being destroyed or disposed of. A requestor may extend the timeframe provided that they notify the appropriate practitioner or Provider of the extension. An extension notice must include the specific reason for the extension, the intended use of the information during the extension, and the expected date that the information is to be destroyed; and
   d. A statement that the requestor destroys the information and all copies in their possession or control, causes it to be destroyed, or return the information and all copies of it before or immediately after the length of time specified in paragraph (c.) has expired.

B. In addition, the person or entity requesting the medical record information must submit a copy of the written request to the Member within 30 days of receipt of the requested information, unless the Member has signed a written waiver in the form of a letter that is submitted by the Member to the health care practitioner of IEHP waiving this notification.

C. This section does not apply to the disclosure or use of medical information by a law
7. MEDICAL RECORDS REQUIREMENTS

B. Information Disclosure and Confidentiality of Medical Records

enforcement agency or a regulatory agency when required for an investigation of unlawful activity or for licensing, certification, or regulatory purposes, unless otherwise prohibited by law.

D. A covered entity must obtain an authorization for any use or disclosure of psychotherapy notes except in the following situations under 45 CFR Section 164.508(a)(2):

1. To carry out the following treatment, payment, or health care operations:
   a. Use of the originator of the psychotherapy notes for treatment;
   b. Use or disclosure by the covered entity for its own training programs; and
   c. To defend itself in a lawsuit.

IEHP Oversight and Monitoring:

A. IEHP monitors the confidentiality of Member medical records and the appropriate release of confidential information through initial PCP Site Review and Medical Record Review Surveys.

B. IEHP monitors IPA compliance with Member medical record confidentiality policies and procedures through annual IPA Delegation Oversight Audits.

C. IEHP monitors IPA compliance with medical record confidentiality by ensuring that committee members have signed a confidentiality statement protecting Member information.

D. HIPAA compliance is enforced by the Office of Civil Rights of the Department of Health and Human Services.
7. MEDICAL RECORDS REQUIREMENTS

C. Informed Consent

APPLIES TO:

A. This policy applies to all IEHP Medicare DualChoice (HMO SNP) and IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan) Members.

POLICY:

A. Informed consent for treatment, procedures or other interventions must be obtained by the practitioner prior to initiation of the procedure.

B. Informed consent information must be provided with consideration of the Member’s linguistic needs and literacy level.

C. Informed consent is required whenever any surgical or invasive diagnostic procedure is to be performed or when general, local or regional anesthesia is to be used.

PROCEDURE:

A. Practitioners must obtain appropriate written consent from Members before the actual performance of any diagnostic or treatment procedure of an intrusive nature.

B. In the event that a Member is under legal age or is unable to sign the consent, the legal guardian or a person specifically designated by the Member, can sign on their behalf. The signing individual must document their relationship to the Member on the consent form.

C. The consent form must include the following:
   1. Member name;
   2. ID #;
   3. Procedure;
   4. Diagnosis;
   5. Risks;
   6. Benefits;
   7. A statement signed by the Member that the procedure has been explained to the Member and that the Member fully understands the procedure, benefits, and risks;
   8. A witness’ signature; and

D. A informed consent procedure must be followed in the case of sterilization for Members enrolled in IEHP DualChoice (See Attachments, “PM 330 Sterilization Consent Form – English” and “PM 330 Sterilization Consent Form – Spanish” in Section 10).
7. MEDICAL RECORDS REQUIREMENTS

C. Informed Consent

E. A informed consent procedure must be in place for Members who seek out of plan STD, Family Planning and HIV testing services, and who wish to maintain medical record confidentiality but allow for transmission of information necessary for billing purposes.


G. Practitioners are required to must keep copies of signed informed consent forms in the Member’s medical record as well as submit these with any claims forms.
7. MEDICAL RECORDS

D. Durable Power of Attorney for Healthcare – Advance Directive

APPLIES TO:
A. This policy applies to all IEHP Medicare DualChoice (HMO SNP) and IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan) Members.

POLICY:
A. IEHP requires that all health care providers comply with the Patient Self Determination Act (PSDA) of 1990, which states that all healthcare providers must inform patients (Members) of their right to formulate an advance directive in writing. This policy, in regards to PSDA, applies to all healthcare providers and Members age 18 and older, as well as Emancipated Minors.

B. IEHP and/or the delegated IPA allow a Member’s representative/caregiver to facilitate care or treatment decisions for a Member who is unable to do so.

PURPOSE:
A. To ensure compliance with State law and allow a Member or Member’s representative/caregiver to be involved in decisions about a Member’s care and treatment.

PROCEDURE:
A. The provisions of the PSDA that affect health care providers (i.e., healthcare facilities, practitioners, HMOs and IPAs) are as follows:

1. Every health care provider that receives payments for Medicare must give each Member a statement of rights in regard to making healthcare decisions.

2. The healthcare provider must ask all Members age eighteen (18) and older, as well as Emancipated Minors, if they have an advance directive. A negative or positive response must be documented in the Member’s medical record. Healthcare may not be withheld or delayed for lack of an advance directive.

3. If the Member has an advance directive, the healthcare provider must request that the Member bring the provider a copy to be placed in the Member’s medical record.

4. If the Member does not have an advance directive and requests further information, the healthcare provider must have written educational materials on hand regarding the PSDA.

5. Healthcare providers are not required to assist Members with formulating advance directives. They are only required to notify Members eighteen (18) and older, as well as Emancipated Minors of their advance directive rights.
B. IEHP and/or the delegated IPA will have a written process that allows a Member's representative/caregiver to manage care or treatment decisions when the Member is incapacitated and unable to do so.

C. The process will comply with State and Federal law.

D. Neither IEHP nor the delegated IPA is required to provide care that conflicts with an Advance Directive.

E. IEHP and/or the delegated IPA will allow the Member or the Member's representative/caregiver to be involved in decisions about withholding resuscitative services or declining/withdrawing life-sustaining treatment.

F. If IEHP or the delegated IPA has requested a conscience protection waiver from CMS, the Member materials must contain:
   1. Clarification of any differences between organization-wide objections and conscience objections that may be raised by individual practitioners;
   2. The source of the State's legal authority permitting a conscience objection; and
   3. A description of the range of medical conditions, procedures and limitations affected by the conscience objection.

G. Through its written Member materials, IEHP must:
   1. Inform Members at enrollment, and annually thereafter of their right to accept or refuse treatment and to complete an Advance Directive and inform the Member how to implement that right.
   2. Inform Members of their right to file a complaint with the State survey and certification agency.

H. IEHP and/or the delegated IPA must have a policy for medical record documentation of Advance Directives that require:
   1. Documentation of Advance Directives to be in a prominent part of the Member's medical record.

I. Documentation on whether or not a Member has executed an Advance Directive to be included in the medical record.

J. IEHP and/or the delegated IPA will demonstrate that its staff that handle IEHP DualChoice Members (e.g., Medicare MSR, Complex CM, DualChoice CM) are provided education on Advance Directives.

K. Member may change, cancel and/or amend an advance directive at any time.

L. The “Healthcare Advance Directive” form can be utilized in the medical record to satisfy the advance directive requirement (See Attachments, “Durable Power of Attorney for
7. MEDICAL RECORDS

D. Durable Power of Attorney for Healthcare – Advance Directive

## 7. MEDICAL RECORDS REQUIREMENTS

Attachments

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>POLICY CROSS REFERENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consent for Special Procedure - English</td>
<td>7C</td>
</tr>
<tr>
<td>Consent for Special Procedure - Spanish</td>
<td>7C</td>
</tr>
<tr>
<td>Durable Power of Attorney for Healthcare - English</td>
<td>7D</td>
</tr>
<tr>
<td>Durable Power of Attorney for Healthcare - Spanish</td>
<td>7D</td>
</tr>
</tbody>
</table>
CONSENT FOR SPECIAL PROCEDURE

Surgical and diagnostic procedures all may involve calculated risks of complications from both known and unknown causes and no guarantee has been made as to result or cure. Except in a case of emergency or exceptional circumstances, these procedures are therefore not performed upon patients unless and until the patient has had an opportunity to discuss them with his physician. Each patient has the right to consent to, or refuse any proposed procedure based upon the description or explanation received.

Your physician has determined that the special procedure listed below may be beneficial in the diagnosis and treatment of your condition. Upon your authorization and consent, a physician selected by your attending physician will perform these special procedures for you.

Your signature opposite the procedures listed below constitutes your acknowledgment that you have read and agreed to the foregoing and that the procedure has been adequately explained to you and that you have all the information that you desire and that you authorize and consent to the performance of these procedures.

Diagnosis: ____________________________

Procedure: ____________________________

Date and Time: _______________________

Physician/Provider: ___________________

Patient’s Signature: ___________________

Parent, Legal Guardian or Representative: ___________________

Witness Signature: ___________________

Patient Name: ___________________________ DOB: __________ Member #: __________
CONSENTIMIENTO PARA PROCEDIMIENTO ESPECIAL

Estos procesos quirúrgicos y diagnósticos podrían involucrar riesgos calculados de complicaciones de ambas causas tanto conocidas como desconocidas y no se hace garantía en cuanto a los resultados ó la cura. Salvo en casos de emergencia ó circunstancias excepcionales, estos procesos no serán efectuados en los pacientes a no ser y hasta que el(la) paciente haya tenido oportunidad de discutirlas con su médico. Cada paciente tiene todo el derecho a dar consentimiento ó rechazar cualquier proceso que se proponga basado en la descripción ó explicación que haya recibido.

Su médico ha determinado que el proceso especial mencionado abajo puede ser beneficioso en el diagnóstico y tratamiento de la condición que le afecta. Una vez que se haya recibido su autorización y consentimiento, estos procesos especiales se efectuarán en usted por un médico seleccionado por su médico de cabecera.

Su firma al lado opuesto de los procesos mencionados abajo constituye su reconocimiento que usted ha leído y concuerda con lo precedente y que el proceso le ha sido explicado totalmente y que usted tiene toda la información que desea y que usted da su autorización y consentimiento para que se efectúen estos procedimientos.

Diagnóstico: __________________________________________
Procedimiento: ________________________________________

Fecha y Horario: _________________________________________
Médico/Proveedor: ________________________________________

Firma del(a) Paciente: ___________________________________
Padre/Madre o Tutor(a) Legal: ______________________________
Firma del(a) Testigo: ____________________________________

Name of Patient: ___________________________ DOB: ________ Member #: __________
Provider Name: ____________________________ Consent – Special Procedures.doc
# DURABLE POWER OF ATTORNEY FOR HEALTHCARE

*You have the right to make decisions about your medical treatment*

This brochure explains your rights to make healthcare decisions and how you can plan what should be done when you can't speak for yourself. A federal law requires us to provide you with this information. We hope this information is helpful and will increase your control over your medical treatment.

<table>
<thead>
<tr>
<th>Who decides about my treatment?</th>
<th>Your doctors will give you information and advice about treatment and options. You have the right to choose. You can “YES” to the treatment(s) you want. You can say “NO” to any treatment you don’t want – even if the treatment might prolong your life.</th>
</tr>
</thead>
<tbody>
<tr>
<td>How do I know what I want?</td>
<td>Your doctor must tell you about your medical condition and about what different treatments can do for you. Many treatments have “side effects.” Your doctor must offer you information about serious problems that medical treatment is likely to cause you. Often, more than one treatment might help you and people have different ideas about which is the best one. Your doctor can tell you which treatments are available to you, but your doctor can’t choose for you. That choice depends on what is important to you.</td>
</tr>
<tr>
<td>What if I am too sick to decide?</td>
<td>If you can’t make treatment decisions, your doctor will ask your closest available relative or friend to help decide what is best for you. Most of the time, that works well. But sometimes everyone doesn’t agree about what should be done. That’s why it is helpful if you say to someone in advance what you desire if something should happen and you cannot speak for yourself. There are several kinds of “advance directives” that you can use to say what you want and who you want to speak on your behalf. One kind of advance directive under California law lets you name someone to make healthcare decisions when you are unable. This form is called a DURABLE POWER OF ATTORNEY FOR HEALTHCARE.</td>
</tr>
<tr>
<td>Who can fill out this form?</td>
<td>You can if you are 18 year of age or older and of sound mind. You do not need a lawyer to fill it out.</td>
</tr>
<tr>
<td>Who can I name to make medical treatment decisions when I am unable to do so?</td>
<td>You can choose an adult relative or a friend whom you trust as your “agent” to speak on your behalf when you are too ill to make your own healthcare decisions.</td>
</tr>
</tbody>
</table>

---

Patient Name: ___________________  DOB: __________  Member #: ________

Provider Name: ___________________
<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>How does this person know what I would want?</td>
<td>After you choose someone, talk to that person about what you would want. You can also write down in the DURABLE POWER OF ATTORNEY FOR HEALTHCARE when you would and wouldn't want medical treatment. Talk to your doctor about what you want and give your doctor a copy of the DURABLE POWER OF ATTORNEY. Also give a copy to the person you named as your “agent.” You should carry a copy with you in the event you are hospitalized or enter a treatment center so that it may be placed into your medical record. Sometimes treatment decisions are hard to make and it truly helps your family and your doctors if they know what you want concerning healthcare decisions.</td>
</tr>
<tr>
<td>What if I don’t have anybody to make decisions for me?</td>
<td>You can use another kind of advance directive to write down your wishes about medical treatment. This is often called a “living will” because it takes effect while you are still alive but have become unable to speak for yourself. The California Natural Death Act lets you sign a “living will” called a DECLARATION. Anyone 18 years old or older and of sound mind may sign one. When you sign a DECLARATION it tells your doctors that you don’t want any treatment that would only prolong your life. All life-sustaining treatment would be stopped if you were terminally ill and your death was expected soon, or if you were permanently unconscious or “brain dead.” You would still receive treatment to keep you comfortable and pain free, however. <em>Your doctor must follow your wishes and desires about limiting treatment or turn your care over to another doctor who will. Your doctors are also legally protected when they follow your wishes.</em></td>
</tr>
<tr>
<td>Are there other wills I can use?</td>
<td>Instead of using the DECLARATION in the Natural Death Act, you can use any of the available “living will” forms. You can use a DURABLE POWER OF ATTORNEY FOR HEALTHCARE form without naming an agent. Or you can simply write down your wishes on a piece of paper. Your doctors and family can use what you write in deciding about your treatment. But “living wills” that don’t meet the requirements of the Natural Death Act don’t give as much legal protection for your doctors if a disagreement arises about following your wishes.</td>
</tr>
<tr>
<td>What if I change my mind?</td>
<td>You can change OR revoke any of these documents at any time as long as you can communicate your wishes. Be sure to let your doctors, family, friends and any agent you may have appointed know if you decide to change or revoke your advance directive.</td>
</tr>
<tr>
<td>Do I have to fill out one of these forms?</td>
<td>No, you do not have to fill out any of these forms if you do not want to. You can just talk with your doctor(s) and ask them to write down what you’ve said in your medical chart. And you can talk with your family. But people will be more clear about your treatment wishes if you have them written down. And your wishes are more likely to be followed in the manner you wanted if they are written down.</td>
</tr>
</tbody>
</table>

---

**Patient Name:____________________  DOB:____________________  Member #:____________________**

**Provider Name:____________________**
**INLAND EMPIRE HEALTH PLAN**

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Will I still be treated if I do not fill out these forms?</td>
<td><strong>ABSOLUTELY.</strong> You will still get full medical treatment. We just want you to know that, if you should become too sick to make decisions, someone else will have to make them for you. Remember that: <em><strong>A DURABLE POWER OF ATTORNEY FOR HEALTHCARE</strong></em> lets you name someone to make treatment decisions for you. That person can make most medical decisions not just those about life-sustaining treatment—when you can’t speak for yourself. Besides naming an agent, you can also use the form to say when you would and wouldn’t want particular kinds of treatment. If you don’t have someone you want to name to make your decisions when you can’t, you can sign a NATURAL DEATH ACT DECLARATION. This DECLARATION says that you do not want life-prolonging treatment if you are terminally ill or permanently unconscious (brain dead).*** (The California Consortium on Patient Self-Determination prepared the preceding text, which has been adopted by the California Department of Health Services to implement Public Law 101-508).</td>
</tr>
<tr>
<td>What else do I need to know about making future health care decisions?</td>
<td>We have provided you with this information concerning advance directives so that you can fully participate in planning your future health care decisions. Unfortunately, every family must face the possibility of serious illness in which important decisions must be made. We believe it is never too early to think about decisions that may be very important to you in the future, and to discuss these topics with your family, friends, and other interested persons. Finally, rest assured YOUR MEDICAL PROVIDER does not condition the provision of care or otherwise discriminate against anyone based on whether or not the person has executed an advance directive. It is strictly up to you to decide and to inform your doctor of whether or not you have completed an advance directive and then provide them a copy of it. Also, remember to bring a copy of your advance directive when you check into a hospital or other health facility so that it can be kept with your medical records.</td>
</tr>
</tbody>
</table>
| How can I get more information about advance directives?                | **To obtain an advance directive form, attend a workshop, or to receive free assistance in completing an advance directive, you may call the California Health Decisions at:**  
  (213) 742-6395  
  **OR**  
  (714) 647-4920 |

---

Patient Name: ___________  DOB: ___  Member #: ___________  
Provider Name: ___________
### Durable Power of Attorney for Healthcare

**INLAND EMPIRE HEALTH PLAN**

**PLEASE READ THE FOLLOWING FOUR (4) STATEMENTS AND PLACE YOUR INITIALS AFTER EACH OF THE STATEMENTS BELOW:**

<table>
<thead>
<tr>
<th></th>
<th>Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>I have been given written materials about my right to accept OR refuse medical treatments.</td>
</tr>
<tr>
<td>2</td>
<td>I have been informed of my rights to formulate Advance Directives.</td>
</tr>
<tr>
<td>3</td>
<td>I understand that I am not required to have an Advance Directive in order to receive medical treatment at this healthcare facility.</td>
</tr>
<tr>
<td>4</td>
<td>I understand that the terms of any Advance Directive that I have executed will be followed by the healthcare facility and my care givers to the extent permitted by law.</td>
</tr>
</tbody>
</table>

**PLEASE CHECK THE FOLLOWING STATEMENTS THAT MAY APPLY.**

<table>
<thead>
<tr>
<th></th>
<th>Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>I <strong>HAVE</strong> executed an Advance Directive.</td>
</tr>
<tr>
<td>2</td>
<td>A <strong>COPY</strong> of my Advance Directive has been requested by a medical office staff person.</td>
</tr>
<tr>
<td>3</td>
<td>I <strong>HAVE NOT</strong> executed an Advance Directive.</td>
</tr>
<tr>
<td>4</td>
<td>I <strong>REQUEST</strong> further information regarding Advance Directives.</td>
</tr>
</tbody>
</table>

Print your name here: __________________________ SSI #: __________________________

Sign your name here: __________________________ DATE: __________________________

Witnessed by: __________________________ Title: __________________________ Date: __________________________

**Patient Name:** __________________________ **DOB:** __________________________ **Member #:** __________________________

**Provider Name:** __________________________
FORM 3-1

ADVANCE HEALTH CARE DIRECTIVE

INSTRUCTIONS

Part 1 of this form lets you name another individual as agent to make health care decisions for you if you become incapable of making your own decisions, or if you want someone else to make those decisions for you now even though you are still capable. You may also name an alternate agent to act for you if your first choice is not willing, able, or reasonably available to make decisions for you.

Your agent may not be an operator or employee of a community care facility or a residential care facility where you are receiving care, or your supervising health care provider or an employee of the health care institution where you are receiving care, unless your agent is related to you or is a coworker.

Unless you state otherwise in this form, your agent will have the right to:

1. Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition.
2. Select or discharge health care providers and institutions.
3. Approve or disapprove diagnostic tests, surgical procedures, and programs of medication.
4. Direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care, including cardiopulmonary resuscitation.
5. Donate organs or tissues, authorize an autopsy, and direct disposition of remains.

However, your agent will not be able to commit you to a mental health facility, or consent to convulsive treatment, psychosurgery, sterilization or abortion for you.

Part 2 of this form lets you give specific instructions about any aspect of your health care, whether or not you appoint an agent. Choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive, as well as the provision of pain relief. You also can add to the choices you have made or write down any additional wishes. If you are satisfied to allow your agent to determine what is best for you in making end-of-life decisions, you need not fill out Part 2 of this form.

Give a copy of the signed and completed form to your physician, to any other health care providers you may have, to any health care institution at which you are receiving care, and to any health care agents you have named. You should talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take the responsibility.

You have the right to revoke this advance health care directive or replace this form at any time.

PART 1—POWER OF ATTORNEY FOR HEALTH CARE

DESIGNATION OF AGENT: I designate the following individual as my agent to make health care decisions for me:

Name of individual you choose as agent:

Address:

Telephone: (home phone) (work phone) (cell/pager)
Form 3-1 Advance Health Care Directive

OPTIONAL: If I revoke my agent’s authority or if my agent is not willing, able, or reasonably available to make a health care decision for me, I designate as my first alternate agent:

Name of individual you choose as first alternate agent: __________________________

Address: ________________________________________________________________

Telephone: __________________________ (home phone) ______________________ (work phone) ______________________ (cell/pager)

OPTIONAL: If I revoke the authority of my agent and first alternate agent or if neither is willing, able, or reasonably available to make a health care decision for me, I designate as my second alternate agent:

Name of individual you choose as second alternate agent: __________________________

Address: ________________________________________________________________

Telephone: __________________________ (home phone) ______________________ (work phone) ______________________ (cell/pager)

AGENT’S AUTHORITY: My agent is authorized to make all health care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care to keep me alive, except as I state here:

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

(Add additional sheets if needed.)

WHEN AGENT’S AUTHORITY BECOMES EFFECTIVE: My agent’s authority becomes effective when my primary physician determines that I am unable to make my own health care decisions.  ____________________________________________ (Initial here)

OR

My agent’s authority to make health care decisions for me takes effect immediately.  ____________________________________________ (Initial here)

AGENT’S OBLIGATION: My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.
AGENT'S POSTDEATH AUTHORITY: My agent is authorized to make anatomical gifts, authorize an autopsy and direct disposition of my remains, except as I state here or in Part 3 of this form:

(Add additional sheets if needed.)

PART 2 - INSTRUCTIONS FOR HEALTH CARE

If you fill out this part of the form, you may strike any wording you do not want.

END-OF-LIFE DECISIONS: I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below:

Choice Not To Prolong Life:

I do not want my life to be prolonged if (1) I have an incurable and irreversible condition that will result in my death within a relatively short time, (2) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (3) the likely risks and burdens of treatment would outweigh the expected benefits.

OR

Choice To Prolong Life:

I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

(Initial here)

RELIEF FROM PAIN: Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death:

(Add additional sheets if needed.)

OTHER WISHES: (If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:

(Add additional sheets if needed.)
PART 3 – DONATION OF ORGANS AT DEATH (OPTIONAL)

Upon my death:
I give any needed organs, tissues, or parts

OR

I give the following organs, tissues, or parts only:

My gift is for the following purposes:

Transplant

Research

Therapy

Education

PART 4 – PRIMARY PHYSICIAN (OPTIONAL)

I designate the following physician as my primary physician:

Name of Physician: __________________________ Telephone: __________________________
Address: ____________________________________________

OPTIONAL: If the physician I have designated above is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician:

Name of Physician: __________________________ Telephone: __________________________
Address: ____________________________________________

PART 5 – SIGNATURE

The form must be signed by two qualified witnesses, or acknowledged before a notary public.

SIGNATURE: Sign and date the form here:

Date: __________________________
Name: __________________________
(address your name) (print your name)
Address: ____________________________________________
STATEMENT OF WITNESSES: I declare under penalty of perjury under the laws of California (1) that the individual who signed or acknowledged this advance health care directive is personally known to me, or that the individual's identity was proven to me by convincing evidence (2) that the individual signed or acknowledged this advance directive in my presence, (3) that the individual appears to be of sound mind and under no duress, fraud, or undue influence, (4) that I am not a person appointed as agent by this advance directive, and (5) that I am not the individual's health care provider, an employee of the individual's health care provider, the operator of a community care facility, an employee of or operator of a community care facility, the operator of a residential care facility for the elderly, nor an employee of an operator of a residential care facility for the elderly.

FIRST WITNESS

Name: ____________________________ Telephone: ____________________________

Address: ____________________________

Signature of Witness: ____________________________ Date: ____________________________

SECOND WITNESS

Name: ____________________________ Telephone: ____________________________

Address: ____________________________

Signature of Witness: ____________________________ Date: ____________________________

ADDITIONAL STATEMENT OF WITNESSES: At least one of the above witnesses must also sign the following declaration.

I further declare under penalty of perjury under the laws of California that I am not related to the individual executing this advance health care directive by blood, marriage, or adoption, and to the best of my knowledge, I am not entitled to any part of the individual's estate upon his or her death under a will now existing or by operation of law.

Signature of Witness: ____________________________

Signature of Witness: ____________________________

YOU MAY USE THIS CERTIFICATE OF ACKNOWLEDGMENT BEFORE A NOTARY PUBLIC INSTEAD OF THE STATEMENT OF WITNESSES.

State of California )

County of ____________________________ ) SS.

On (date) ____________________________, before me, (name and title of officer) ____________________________, personally appeared (name(s) of signer(s)) ____________________________,

☐ personally known to me OR ☐ proved to me on the basis of satisfactory evidence

to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

WITNESS my hand and official seal. (Civil Code Section 1189)

Signature of Notary: ____________________________
PART 6—SPECIAL WITNESS REQUIREMENT

If you are a patient in a skilled nursing facility, the patient advocate or ombudsman must sign the following statement:

STATEMENT OF PATIENT ADVOCATE OR OMBUDSMAN

I declare under penalty of perjury under the laws of California that I am a patient advocate or ombudsman as designated by the State Department of Aging and that I am serving as a witness as required by Section 4675 of the Probate Code.

Date: ________________________________

Name: ________________________________
(sign your name) (print your name)

Address: ________________________________
CARTA PODER DURABLE PARA EL CUIDADO DE SALUD

Usted tiene el derecho a tomar decisiones sobre su tratamiento médico

Este folleto le explica sus derechos a tomar decisiones del cuidado de salud y cómo usted puede planear lo que se debe hacer cuando usted no puede hablar por sí mismo(a). Una ley federal requiere que le proveamos esta información. Esperamos que esta información le sea útil y aumente su control sobre su tratamiento médico.

¿Quién decide sobre mi tratamiento?

Su médico lo dará información y consejo sobre tratamiento y opciones. Usted tiene el derecho a escoger. Puede decir que “SI” al(los) tratamiento(s) que quiera. Puede decir que “NO” a cualquier tratamiento que no quiera – aunque el tratamiento pueda prolongar su vida.

¿Cómo sé lo que quiero?

Su médico debe decirle sobre su condición médica y sobre qué pueden hacer por usted los diversos tratamientos. Muchos tratamientos tienen “efectos secundarios.” Su médico debe ofrecerle información sobre problemas serios que pueda ocasionar un tratamiento medial.

A menudo, más de un tratamiento podría ayudarle – y las personas tienen diversas ideas sobre cuál es el mejor. Su médico le puede decir cuáles tratamientos hay disponibles para usted, pero su médico no puede escoger por usted. Esta selección depende en qué es importante para usted.

¿Qué tal si estoy muy enfermo(a) para decidir?

Si usted no puede tomar decisiones de tratamiento, su médico le pedirá a su familiar o amistad cercana más disponible, a que ayude a decidir qué es lo mejor para usted. La mayoría de las veces, esto funciona bien. Pero a veces no todos se ponen de acuerdo sobre qué debe hacerse. Por eso es provechoso si le dice a alguien por adelantado – qué es lo que desea si sucediera algo y usted no puede hablar por sí mismo(a). Existen varios tipos de “instrucciones por adelantado” que usted puede usar para decir lo que quiere, y quién puede hablar por usted.

Un tipo de instrucciones por adelantado bajo las leyes de California le permite nombrar a alguien que tome decisiones del cuidado de salud cuando usted no puede hacerlo. Este documento se llama CARTA PODER DURABLE PARA EL CUIDADO DE SALUD.

¿Quién puede llenar este documento?

Usted puede, si tiene 18 años.

¿A quién puedo nombrar para que tome decisiones de tratamiento médico cuando yo no pueda?

Usted puede escoger a un familiar adulto o una amistad en que confíe como su “agente” para que hable por usted cuando se encuentre muy enfermo(a) para tomar sus propias decisiones del cuidado de salud.

Patient Name: ___________________________ DOB: ___________ Member #: ___________

Provider Name: ___________________________ Durable Power of Attorney-op.doc.1
¿Cómo es que sabe esta persona 'o que yo quiera?

Después que escoja a alguien, hable con esa persona sobre lo que usted querría, también puede escribir en la CARTA PODER DURABLE PARA EL CUIDADO DE SALUD cuando se quiera o no se quiera tratamiento médico. Hable con su médico sobre lo que usted quiere y dele a su médico una copia de la CARTA PODER DURABLE. También dele una copia a la persona que usted nombró como su "agente." Usted debe portar una copia en caso de que se hospitalice o para el centro de tratamiento - para que se coloque en su recórd médico. A veces las decisiones de tratamiento son difíciles de tomar y en realidad ayuda a su familia y sus médicos si ellos saben lo que usted quiere referente a decisiones del cuidado de salud.

¿Qué tal si no tengo nadie que pueda tomar decisiones por mí?

Usted puede usar otro tipo de instrucciones por adelantado para escribir sus deseos sobre tratamiento médico. Esto se llama a menudo un "testamento viviente" porque entra en vigor mientras aún está con vida pero es incapaz de hablar por sí mismo(a). La Ley de Muerte Natural de California le permite firmar un "testamento viviente" llamado una DECLARACIÓN. Cualquier persona mayor de 18 años de edad puede firmar uno. Cuando se firma una DECLARACIÓN esto le dice a su médico que usted no quiere ningún tratamiento que solo lo prolongaría la vida. Todo tratamiento que mantiene la vida cesará si se encuentra con enfermedad incurable y se espera un desenlace pronto, o sí estuviese permanentemente inconsciente o de "muerte cerebral." Aún así, usted recibiría tratamiento para mantenerle confortable y sin dolor. Su médico debe seguir sus deseos al pie de la letra sobre limitar su tratamiento, o deberá retrograrse su cuidado a otro médico que lo haga. Sus médicos también están protegidos legalmente cuando siguen sus deseos.

¿Existen otros testamentos que pueda usar?

En vez de usar la DECLARACIÓN en la Ley de Muerte Natural, usted puede hacer uso de cualesquiera de los formularios disponibles de "testamento viviente." Puede ejecutar un formulario de CARTA PODER DURABLE PARA EL CUIDADO DE SALUD sin nombrar un(a) agente. O sencillamente puede escribir sus deseos en un pedazo de papel. Sus médicos y familiares pueden usarlo lo que usted escribió decidendo su tratamiento. Pero los "testamentos vivientes" que no reúnen los requisitos de la Ley de Muerte Natural no les da tanta protección legal a sus médicos si surgiase un descuerdo para seguir sus deseos.

¿Qué tal si cambio de parecer?

Usted puede cambiar O revocar cualesquiera de estos documentos en cualquier momento siempre y cuando pueda comunicar sus deseos. Asegúrese de hacerles saber a sus médicos, familiares, amistades y cualquier agente que haya asignado, que usted desea cambiar o revocar sus instrucciones por adelantado.

¿Debo llenar uno de estos formularios?

No, no tiene que llenar ninguno de estos formularios si no lo desea. Simplemente hable con su(s) médico(s) y pídale(a) que escriban en su informe médico lo que le dijo usted, y puede hablar con su familia. Pero queda más claro para las personas que sean sus deseos sobre tratamiento si los tiene por escrito. Y existe mayor probabilidad de seguir sus deseos de la manera que usted quiere si están por escrito.
<table>
<thead>
<tr>
<th>¿Seré tratado(a) aunque no lo esté expresamente?</th>
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<tbody>
<tr>
<td><strong>ABSOLUTAMENTE</strong>. Aún recibirá tratamiento médico completo. Solo queremos dejarle saber que si se enferma demasiado como para tomar decisiones, alguien más tendrá que tomarlas por usted. Recuerde que: <strong>UNA CARTA PODER DURABLE PARA EL CUIDADO DE SALUD</strong> le permite nombrar a alguien que tome decisiones por usted. <strong>Esa persona puede tomar la mayoría de las decisiones médicas</strong> no solo las de tratamiento que mantengan la vida, cuando usted no pueda hablar por sí mismo(a). Además de nombrar un(a) agente, también puede usar el formulario para decir cuándo querría o no querría algún tratamiento en particular.</td>
</tr>
<tr>
<td>Si no tiene a alguien que quiera nombrar para que tome las decisiones por usted cuando usted no pueda hacerlo, puede entonces firmar una <strong>DECLARACIÓN DE LEY DE MUERTE NATURAL</strong>. Esta DECLARACIÓN dice que usted no quiere tratamiento que prolongue la vida si está desahuciado(a) o permanentemente inconsciente (muerte cerebral).</td>
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<tr>
<th>¿Qué más necesito saber acerca de tomar decisiones en el futuro para el cuidado de la salud?</th>
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<tr>
<td>Le hemos provisto con esta información referente a instrucciones por adelantado para que usted pueda participar completamente en la planificación de decisiones futuras del cuidado de salud. Desgraciadamente, cada familia debe enfrentarse a la posibilidad de enfermedad grave donde se deben tomar decisiones importantes. Creemos que nunca es prematuro pensar sobre decisiones que podrían ser muy importantes para usted en el futuro, y discutir estos temas con su familia, amistades, y otras personas interesadas. Finalmente, siéntase seguro(a) que SU PROVEEDOR MÉDICO no condiciona la provisión de cuidados ni discrimina contra nadie basado en si la persona haya ejecutado o no unas instrucciones por adelantado. Depende estrictamente de usted el decidir e informarle a su médico si ha llenado o no las instrucciones por adelantado y proporcionarle una copia de éste. Asimismo, recuerde traer una copia de sus instrucciones por adelantado cuando ingrese a un hospital u otra instalación de salud para que se mantenga con sus registros médicos.</td>
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<tr>
<th>¿Cómo puedo obtener mayor información sobre instrucciones por adelantado?</th>
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<tbody>
<tr>
<td><strong>Para obtener un formulario de instrucciones por adelantado, asistir a un taller, o para recibir asistencia gratuita en llenar una instrucción por adelantado, puede llamar a Decisiones de Salud de California al:</strong> (213) 742-6395 O (714) 647-4920</td>
</tr>
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**Patient Name:**

**DOB:**

**Member #:**

**Provider Name:**

**Durable Power of Attorney Act, Inc.**
FAVOR DE LEER LAS SIGUIENTES 4 (CUATRO) DECLARACIONES Y COLOQUE SUS INICIALES A LA IZQUIERDA DE CADA DECLARACIÓN DE ABAJO:

1. Se me ha dado material por escrito sobre mi derecho de aceptar o rechazar tratamientos médicos.

2. Me han informado sobre mis derechos de formular Instrucciones por Adelantado.

3. Tengo entendido que no se requiere que tenga Instrucciones por Adelantado para poder recibir tratamiento médico en estas instalaciones del cuidado de la salud.

4. Tengo entendido que los términos de cualquier Instrucción por Adelantado que haya ejecutado serán honrados por la institución del cuidado a la salud y mis asistentes de cuidado hasta donde lo permite la ley.

FAVOR DE MARCAR LAS SIGUIENTES DECLARACIONES QUE CORRESPONDAN.

1. HE ejecutado unas Instrucciones por Adelantado.

2. El personal médico de la oficina me ha solicitado UNA COPIA de mis Instrucciones por Adelantado.

3. Yo NO HE ejecutado unas Instrucciones por Adelantado.

4. PIDO mayor información sobre Instrucciones por Adelantado.

Escriba su nombre aquí: ___________________________ NÚM. SSI: ___________________________

Firme su nombre aquí: ___________________________ FECHA: ___________________________

F: Testigo: ___________________________ Título: ___________________________ Fecha: ___________________________

Patient Name: ___________________________ DOB: ___________________________ Member #: ___________________________

Provider Name: ___________________________ Durable Power of Attorney-sp.doc4
La Sección 1 de este formulario le permite nombrar a otro individuo como representante para que tome las decisiones de atención de la salud por usted en caso que llegue a ser incapaz de tomar sus propias decisiones o si usted quiere que alguien más tome esas decisiones por usted ahora aunque todavía sea capaz. También puede nombrar a un representante suplente que actúe por usted si su primera elección no está disponible, no es capaz o no está razonablemente accesible para tomar decisiones por usted.

Su representante no puede ser un operador o empleado de un establecimiento de atención compulsiva y un establecimiento de atención residencial donde lo estén atendiendo, ni su proveedor de atención de la salud encargado de la supervisión o un empleado de la institución de atención de la salud donde usted está recibiendo la misma, a menos que su representante esté emparejado con usted o sea compañero de trabajo.

A menos que indique lo contrario en este formulario, su representante tendrá el derecho de:

1. Prestar o negar el consentimiento a cualquier atención, tratamiento, servicio o procedimiento para mantener, diagnosticar o afectar de otro modo una enfermedad física o mental.
2. Seleccionar o rechazar proveedores e instituciones de atención de la salud.
3. Aprovechar o desaprovechar pruebas diagnósticas, procedimientos quirúrgicos y programas de medicamentos.
4. Dirigir el proveimiento, la negación o la cesión de nutrición e hidratación artificial y todas las demás formas de atención de la salud, incluyendo reanimación cardiopulmonar.
5. Donar órganos o tejidos, autorizar una autopsia y ordenar la disposición final de los restos.

Sin embargo, su representante no podrá intervenir en un establecimiento psiquiátrico ni dar su consentimiento para que usted sea sometido a tratamiento convulsivo, psicocirugía, esterilización o aborto.

La Sección 2 de este formulario le permite dar instrucciones específicas acerca de cualquier aspecto de su atención de la salud, ya sea que usted nombre a un representante o no. Se proporcionan opciones para que usted exprese sus deseos acerca del proveimiento, la negación o la reciud de tratamiento para mantenerlo vivo, así como el proveimiento a alivio del dolor. También se proporcionan espacios para que usted aminste las opciones que haya hecho o que anote un deseo adicional. Si está conforme con dejar que su representante determine lo que sea mejor para usted al tomar decisiones relacionadas con el final de la vida, no es necesario que lleve la Parte 2 de este formulario.

Entregues copias del formulario firmado y debidamente llenado a su médico, a cualquier otro proveedor de atención de la salud que pueda tener, a cualquier institución de atención de la salud en la que lo esté atendiendo y a todos los representantes de atención de la salud que haya nombrado. Deberá hablar con la persona que haya nombrado como representante para asegurar que él o ella entienda sus deseos y esté dispuesta a asumir la responsabilidad.

Usted tiene derecho a revocar esta directiva por anticipado de la atención de su salud o a reemplazar este formulario en cualquier momento.
PARTE 1 - PODER NOTARIAL PARA ATENCIÓN DE LA SALUD

DESIGNACIÓN DEL REPRESENTANTE: Designe al siguiente individuo como mi representante para que tome las decisiones de atención de la salud por mí:

Nombre del individuo que usted elija como representante:

Dirección:

Teléfono: (en casa) (teléfono en el trabajo) teléfono celular / localizador

OPCIONAL: Si revoco la autoridad de mi representante o si mi representante no está disponible, no es capaz o no está razonablemente accesible para tomar una decisión de atención de la salud por mí, designo como mi primer representante suplente a:

Nombre de la persona que usted elija como primera alternativa:

Dirección:

Teléfono: (en casa) (teléfono en el trabajo) teléfono celular / localizador

OPCIONAL: Si revoco la autoridad de mi representante y mi primer representante suplente o si ninguno de los dos está disponible, no es capaz o no está razonablemente accesible para tomar una decisión de atención de la salud por mí, designo como mi segundo representante suplente a:

Nombre del individuo que usted elija como su segundo representante suplente:

Dirección:

Teléfono: (en casa) (teléfono en el trabajo) teléfono celular / localizador

AUTORIDAD DEL REPRESENTANTE: Mi representante está autorizado para tomar todas las decisiones de atención de la salud por mí, incluyendo las decisiones para prestar, negar o retirar la nutrición e hidratación artificial y todas las demás formas de atención de la salud para mantenerme vivo, excepto como lo consigne aquí:

(Acuerdos necesarios, agregue hoja adicional.)

Page 2 of 6

California Healthcare Association
CUÁNDO ENTRA EN VIGENCIA LA AUTORIDAD DEL REPRESENTANTE: La autoridad del representante entrará en vigor cuando mi médico de atención primaria determine que no tenga capacidad para tomar decisiones sobre mi atención de la salud. 

Escriba su nombre aquí: (espacio para nombre)

OBLIGACIÓN DEL REPRESENTANTE: Mi representante tomará decisiones de atención de la salud por mí de acuerdo con este poder material para atención de la salud, todas las instrucciones que yo proporcioné en la Parte 2 de este formulario y mis demás deseos en la medida conocida para mi representante. En la medida que mis deseos sean desconocidos, mi representante tomará decisiones de atención de la salud por mí de acuerdo con lo que mi representante determine que es en mi mejor interés para determinar mi mejor interés, mi representante deberá considerar mis valores personales en la medida conocida por el mismo.

AUTORIDAD DEL REPRESENTANTE DESPUÉS DE LA MUERTE: Mi representante está autorizado para hacer decisiones acerca de mi disposición final de mis restos, excepto como yo lo consigne aquí o en la Parte 3 de este formulario.

(Si es necesario, agregue hojas adicionales.)

NOMBRAMIENTO DEL CONSERVADOR: Si es necesario que una corte designe para mí un conservador de mi persona, yo nombraré un conservador designado en este formulario. Si el conservador no está disponible, no es capaz o no está razonablemente accesible para actuar como conservador, nombro a los representantes suplentes que he designado, en el orden en que lo he hecho.

PARTE 2 - INSTRUCCIONES PARA LA ATENCIÓN DE LA SALUD

Si usted firma este parte del formulario, podrá tachar cualquier texto que no quiera.

DECISIONES FINALES DE LA VIDA: Orígenes que mis proveedores de atención de la salud y otros que participen en mi atención, provean, negaren o retenen el tratamiento de acuerdo con la elección que yo haya indicado abajo:

☐ Elección de no prolongar la vida

No quiero que mi vida sea prolongada si (1) tengo una enfermedad incurable e irreversible que resulte mi muerte dentro de un período relativamente corto, (2) pierdo el conocimiento y, con un grado razonable de certeza médica, no lo recuperaré (3) los riesgos y cargas probable del tratamiento serían más graves que los beneficios previstos, o 

☐ Elección de prolongar la vida

Quiero que mi vida sea prolongada tanto como sea posible dentro de los límites de las normas de atención de la salud generalmente aceptadas.

ALIVIO DE DOLOR: Excepto como lo consigne en el siguiente espacio, ordeno que se me proporcione en todo momento tratamiento para el alivio del dolor o las molestias, aunque acelere mi muerte.

(Si es necesario, agregue hojas adicionales.)
PARTe 3 - DONACIón DE ORGáNOS DESpUÉS DE LA MUERTE (OPCIONAL)

Después de mi muerte
Dono todos los órganos, tejidos o partes necesarios.

O

Dono solamente los siguientes órganos, tejidos o partes.

Mi donación es para los siguientes propósitos (tache cualquier de los siguientes que usted no desea):

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<th>Transplante</th>
<th>Investigación</th>
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<tr>
<th>Trasplante</th>
<th>Investigación</th>
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</table>

PARTe 4 - MÉDICO DE ATENCIóN PRIMarIA (OPCIONAL)

Designo al siguiente como mi médico de atención primaria:

Nombre del Médico: ___________________________ Telefono: ___________________________

Dirección: ___________________________

OPCIONAL: Si el médico que he designado no está dispuesto, no es capaz o no está razonablemente accesible para actuar como mi médico de atención primaria, designo al siguiente para que desempeñe este papel:

Nombre del Médico: ___________________________ Telefono: ___________________________

Dirección: ___________________________

PARTe 5 - FIRMA

El formulario debe ser firmado por dos testigos calificados o certificado ante un notario público.

FIRMA: Firmé y puse aquí la fecha en el formulario:

Page 4 of 5

California Healthcare Association
DECLARACIÓN DE LOS TESTIGOS: Declaro bajo pena de perjurio conforme a las leyes de California (1) que el individuo que firmó o certificó esta directiva por anticipado de la atención de la salud es conocido personalmente por mí, a que la identidad del individuo me fue demostrada me evidencia convincente, (2) que el individuo firmó o certificó esta directiva por anticipado en mi presencia, (3) que el individuo parece encontrarse en buen estado mental y físico general, libre de influencia indebida, (4) que no soy la persona designada como representante en esta directiva por anticipado y (5) que no soy el proveedor de atención de la salud del individuo, el operador de un establecimiento de atención comunitaria, un empleado de un operador de un establecimiento de atención comunitaria, el operador de un establecimiento de atención residencial para ancianos, si un empleado de un operador de un establecimiento de atención residencial para personas de edad avanzada.

Nombre: ___________________________ Dirección: ___________________________

Firma del testigo: ______________________ Fecha: ___________________________

SEGUNDO TESTIGO

Nombre: ___________________________ Dirección: ___________________________

Teléfono: ___________________________

Firma del testigo: ______________________ Fecha: ___________________________

DECLARACIÓN ADICIONAL DE LOS TESTIGOS: Por lo menos uno de los testigos mencionados arriba también debe firmar la siguiente declaración:

Declaro además bajo pena de perjurio conforme a las leyes de California que no estoy emparentado por linaje sanguíneo, matrimonio o adopción con el individuo que formaliza esta directiva por anticipado de la atención de la salud, y que a mi (leal) saber y entender, no tengo derecho a parte alguna del caudal hereditario del individuo después de su muerte bajo un testamento actualmente existente o por ministerio de ley.

Firma del testigo: ______________________ Fecha: ___________________________

PARTE 6 – REQUERIMIENTO DE TESTIGO ESPECIAL

Si usted es paciente en un establecimiento con servicio de enfermería especializada, el abogado o defensor civil del paciente debe firmar la siguiente declaración:

California Healthcare Association  Page 3 of 6
DECLARACIÓN DEL ABOGADO O DEFENSOR CÍVICO DEL PACIENTE

Declaro bajo pena de perjurio conforme a las leyes de California que soy abogado o defensor cívico del paciente designado por el Departamento de la Secretaría del Estado y que estoy autorizado como testigo como lo establece la Sección 4675 del Código Testamentario.

Fecha: ___________________________

Nombre: ____________________________
(junte su firma) (escriba su nombre con letras de molde)

Dirección: ________________________________