State of Ohio
Living Will Declaration
Notice to Declarant

The purpose of this Living Will Declaration is to document your wish that life-sustaining treatment, including artificially or technologically supplied nutrition and hydration, be withheld or withdrawn if you are unable to make informed medical decisions and are in a terminal condition or in a permanently unconscious state. This Living Will Declaration does not affect the responsibility of health care personnel to provide comfort care to you. Comfort care means any measure taken to diminish pain or discomfort, but not to postpone death.

If you would not choose to limit any or all forms of life-sustaining treatment, including CPR, you have the legal right to so choose and may wish to state your medical treatment preferences in writing in a different document.

Under Ohio law, a Living Will Declaration is applicable **only to individuals in a terminal condition or a permanently unconscious state**. If you wish to direct medical treatment in other circumstances, you should prepare a Health Care Power of Attorney. If you are in a terminal condition or a permanently unconscious state, this Living Will Declaration takes precedence over a Health Care Power of Attorney.

[You should consider completing a new Living Will Declaration if your medical condition changes or if you later decide to complete a Health Care Power of Attorney. If you have both a Living Will Declaration and a Health Care Power of Attorney, you should keep copies of these documents together. Bring your document(s) with you whenever you are a patient in a health care facility or when you update your medical records with your physician.]

Reset Form

Ohio
Living Will Declaration

[R.C. §2133]

_____

(Print Full Name)

_____

(Birth Date)

This is my Living Will Declaration. I revoke all prior Living Will Declarations signed by me. I understand the nature and purpose of this document. If any provision is found to be invalid or unenforceable, it will not affect the rest of this document.

I am of sound mind and not under or subject to duress, fraud or undue influence. I am a competent adult who understands and accepts the consequences of this action. I voluntarily declare my direction that my dying not be artificially prolonged. [R.C. §2133.02 (A)(1]]

I intend that this Living Will Declaration will be honored by my family and physicians as the final expression of my legal right to refuse certain health care. [R.C.§2133.03(B)(2)]

Definitions

Adult means a person who is 18 years of age or older.

Agent or attorney-in-fact means a competent adult who a person (the "principal") can name in a Health Care Power of Attorney to make health care decisions for the principal.

Anatomical gift means a donation of part or all of a human body to take effect after the donor's death for the purpose of transplantation, therapy, research or education.

Artificially or technologically supplied nutrition or hydration means food and fluids provided through intravenous or tube feedings. *[You can refuse or discontinue a feeding tube, or authorize your Health Care Power of Attorney agent to refuse or discontinue artificial nutrition or hydration.]*

Comfort care means any measure, medical or nursing procedure, treatment or intervention, including nutrition and or hydration, that is taken to diminish a patient's pain or discomfort, but not to postpone death.

CPR means cardiopulmonary resuscitation, one of several ways to start a person's breathing or heartbeat once either has stopped. It does not include clearing a person's airway for a reason other than resuscitation.

Declarant means the person signing the Living Will Declaration.

Do Not Resuscitate or DNR Order means a physician's medical order that is written into a patient's record to indicate that the patient should not receive cardiopulmonary resuscitation.

Health care means any care, treatment, service or procedure to maintain, diagnose or treat an individual's physical or mental health.

Health care decision means giving informed consent, refusing to give informed consent, or withdrawing informed consent to health care.

Health Care Power of Attorney means a legal document that lets the principal authorize an agent to make health care decisions for the principal in most health care situations when the principal can no longer make such decisions. Also, the principal can authorize the agent to gather protected health information for and on behalf of the principal immediately or at any other time. A Health Care Power of Attorney is NOT a financial power of attorney.

The Health Care Power of Attorney document also can be used to nominate person(s) to act as guardian of the principal's person or estate. Even if a court appoints a guardian for the principal, the Health Care Power of Attorney remains in effect unless the court rules otherwise.

Life-sustaining treatment means any medical procedure, treatment, intervention or other measure that, when administered to a patient, mainly prolongs the process of dying.

Living Will Declaration means a legal document that lets a competent adult ("declarant") specify what health care the declarant wants or does not want when he or she becomes terminally ill or permanently unconscious and can no longer make his or her wishes known. It is NOT and does not replace a will, which is used to appoint an executor to manage a person's estate after death.

Permanently unconscious state means an irreversible condition in which the patient is permanently unaware of himself or herself and surroundings. At least two physicians must examine the patient and agree that the patient has totally lost higher brain function and is unable to suffer or feel pain.

Principal means a competent adult who signs a Health Care Power of Attorney.

Terminal condition means an irreversible, incurable, and untreatable condition caused by disease, illness, or injury from which, to a reasonable degree of medical certainty as determined in accordance with reasonable medical standards by a declarant's attending physician and one other physician who has examined the declarant, both of the following apply: (1) there can be no recovery and (2) death is likely to occur within a relatively short time if life-sustaining treatment is not administered.

No Expiration Date. This Living Will Declaration will have no expiration date. However, I may revoke it at any time. [R.C. §2133.04(A)]

Copies the Same as Original. Any person may rely on a copy of this document. [R.C. §2133.02(C)]

Out of State Application. I intend that this document be honored in any jurisdiction to the extent allowed by law. [R.C. §2133.14]

I have completed a **Health Care Power of Attorney**: Yes ☐ No ☐

Notifications. *[Note: You do not need to name anyone. If no one is named, the law requires your attending physician to make a reasonable effort to notify one of the following persons in the order named: your guardian, your spouse, your adult children who are available, your parents, or a majority of your adult siblings who are available.]*

In the event my attending physician determines that life-sustaining treatment should be withheld or withdrawn, my physician shall make a reasonable effort to notify one of the persons named below, in the following order of priority *[cross out any unused lines]*: [R.C. §2133.05(2)(a)]

X out area if not used

First contact's name and relationship: _____

Address: _____

Telephone number(s): _____

Second contact's name and relationship: _____

Address: _____

Telephone number(s): _____

Third contact's name and relationship: _____

Address: _____

Telephone number(s): _____

If I am in a **TERMINAL CONDITION** and unable to make my own health care decisions, OR if I am in a **PERMANENTLY UNCONSCIOUS STATE** and there is no reasonable possibility that I will regain the capacity to make informed decisions, then I direct my physician to let me die naturally, providing me only with **comfort care**.

For the purpose of providing comfort care, I authorize my physician to:

1. Administer no life-sustaining treatment, including CPR;
2. Withhold or withdraw artificially or technologically supplied nutrition or hydration, provided that, if I am in a permanently unconscious state, I have authorized such withholding or withdrawal under **Special Instructions** below and the other conditions have been met;
3. Issue a DNR Order; and
4. Take no action to postpone my death, providing me with only the care necessary to make me comfortable and to relieve pain.

***Special Instructions*.**

☐ **By placing my initials, signature, check or other mark in this box, I specifically authorize my physician to withhold, or if treatment has commenced, to withdraw, consent to the provision of artificially or technologically supplied nutrition or hydration if I am in a permanently unconscious state AND my physician and at least one other physician who has examined me have determined, to a reasonable degree of medical certainty, that artificially or technologically supplied nutrition and hydration will not provide comfort to me or relieve my pain.** [R.C. §2133.02(A)(3) and R.C. §2133.08]

Additional instructions or limitations.

[If the space below is not sufficient, you may attach additional pages.
If you do not have any additional instructions or limitations, write "None" below.]

[The "anatomical gift" language provided below is required by ORC §2133.07(C). Donate Life Ohio recommends that you indicate your authorization to be an organ, tissue or cornea donor at the Ohio Bureau of Motor Vehicles when receiving a driver license or, if you wish to place restrictions on your donation, on a Donor Registry Enrollment Form (attached) sent to the Ohio Bureau of Motor Vehicles.]

[If you use this living will to declare your authorization, indicate the organs and/or tissues you wish to donate and cross out any purposes for which you do not authorize your donation to be used. Please see the attached Donor Registry Enrollment Form for help in this regard. In all cases, let your family know your declared wishes for donation.]

ANATOMICAL GIFT (optional)

Upon my death, the following are my directions regarding donation of all or part of my body:
In the hope that I may help others upon my death, I hereby give the following body parts:
[Check all that apply.]

☐ All organs, tissue and eyes for any purposes authorized by law.

OR

☐ Heart	☐ Lungs	☐ Liver (and associated vessels)	☐ Pancreas/Islet Cells
☐ Small Bowel	☐ Intestines	☐ Kidneys (and associated vessels)	☐ Eyes/Corneas
☐ Heart Valves	☐ Bone	☐ Tendons	☐ Ligaments
☐ Veins	☐ Fascia	☐ Skin	☐ Nerves

For the following purposes authorized by law:
☐All purposes ☐Transplantation ☐Therapy ☐Research ☐Education

If I do not indicate a desire to donate all or part of my body by filling in the lines above, no presumption is created about my desire to make or refuse to make an anatomical gift.

SIGNATURE of DECLARANT

I understand that I am responsible for telling members of my family, the agent named in my Health Care Power of Attorney (if I have one), my physician, my lawyer, my religious advisor and others about this Living Will Declaration. I understand I may give copies of this Living Will Declaration to any person.

I understand that I must sign (or direct an individual to sign for me) this Living Will Declaration and state the date of the signing, and that the signing either must be witnessed by two adults who are eligible to witness the signing OR the signing must be acknowledged before a notary public. [R.C. §2133.02]

I sign my name to this Living Will Declaration

on _____, 20___, at _____, Ohio.

_____
Declarant

[Choose Witnesses OR a Notary Acknowledgment.]

WITNESSES [R.C. §2133.02(B)(1)]

[The following persons CANNOT serve as a witness to this Living Will Declaration:

- *Your agent in your Health Care Power of Attorney, if any;*
- *The guardian of your person or estate, if any;*

- *Any alternate agent or guardian, if any;*
- *Anyone related to you by blood, marriage or adoption (for example, your spouse and children);*
- *Your attending physician; and*
- *The administrator of the nursing home where you are receiving care.]*

I attest that the Declarant signed or acknowledged this Living Will Declaration in my presence, and that the Declarant appears to be of sound mind and not under or subject to duress, fraud or undue influence.

_____/_____ /_____
Witness One's Signature Witness One's Printed Name Date

_____
Witness One's Address

_____ /_____ /_____
Witness Two's Signature Witness Two's Printed Name Date

_____
Witness Two's Address

OR, if there are no witnesses,

NOTARY ACKNOWLEDGMENT [R.C. §2133.02(B)(2)]

State of Ohio
County of _____ ss.

On _____, 20_____, before me, the undersigned notary public, personally appeared _____, declarant of the above Living Will Declaration, and who has acknowledged that (s)he executed the same for the purposes expressed therein. I attest that the declarant appears to be of sound mind and not under or subject to duress, fraud or undue influence.

_____
Notary Public

My Commission Expires: _____

My Commission is Permanent: _____

Instructions for Completing
Ohio Standard HIPAA Authorization Form

This standard authorization form should be used by an individual or their personal representative to give consent to the release of personal health information. This form is not a patient access request under 45 CFR 164.524.

Which form do you use? If you are a Part 2 program (Substance Use Disorder (SUD) provider), or you are releasing records obtained from a Part 2 program, use FORM B. In all other cases, use FORM A. Form A does not need to be used when the exchange of information is for the purposes of treatment, payment and healthcare operations under HIPAA.

- **Part 2 programs** are federally assisted individuals or entities that hold themselves out as providing, and provide, substance use disorder diagnosis, treatment or treatment referral. For more information, see 42 CFR 2.11.

Section I (both FORM A and FORM B)

- Enter the requested information for the individual whose health information is to be released.
- Individuals are not required to provide a Social Security Number (SSN). If the SSN or additional identifying information is missing, an entity may not be able to identify the individual in order to respond to the request. An option is to provide the last 4 digits of the SSN.

Section II (Form A)

- "Disclosing Entity (Name of Covered Entity)" is the health plan/insurer or provider who has the individual's PHI which will be released. Enter the name of the Covered Entity as well as the contact information.
- "Recipient (Person or Entity)" - list the person or organization who should receive the PHI. Enter the contact information (phone number, email address, fax number, mailing address, etc.).

Section II (Form B)

- "Disclosing Entity (Name of Holder of Part 2 Program Information)" is the person or entity who has the individual's substance use disorder information to be released. Enter the name of the Holder of Part 2 Program information as well as the contact information. You may use a general description such as "any drug or alcohol treatment program that has provided services to the individual." More than one person or entity may be named.
- "The information is to be provided to the following" - list the person or organization who should receive the substance use disorder information. This can be an individual, a provider, a third party payer (health plan/insurer), or a non-treating entity, such as a health information exchange, a parole office, or a drug court program. More than one person or entity may be named.
- Use a separate FORM B for each person or organization that will be disclosing information.
- **If "Named Non-Treatment Provider (such as an intermediary or research entity)" is selected then a, b, and/or c must be completed too.** *The form is not complete if this box is checked and no additional information is provided in a, b, and/or c.*
    - A treatment provider relationship exists where an individual has agreed to or is required to be diagnosed, evaluated, or treated by, or to accept consultation from, an individual or entity who provides or agrees to provide the service. For more information, see 42 CFR 2.11.
- Enter the contact information (phone number, email address, fax number, mailing address, etc.).

Section III (both FORM A and FORM B):

- "Reason for Disclosure" must tell why the individual's information is being released.
- "Health Information to be disclosed" - must give a complete description of the information to be released. For Form B, please clearly specify the substance use disorder information that may be released.
- "Specify Time Period, if desired" is to be used, if necessary, to indicate a specific date range for the information to be disclosed (e.g. 7/1/2017 to 1/1/2018).

Section IV (both FORM A and FORM B)

- "Expiration Date or Event" is the specific date or event upon which the consent will expire. Event may be defined as the reason for the authorization or consent (e.g. insurance claim). If no date or event is provided, the authorization or consent will expire in one year.
- The individual whose information is being released should sign and date the form. If the individual is not able to sign the form, the personal representative should sign and date it. If a personal representative signs the form, indicate the relationship of the personal representative by selecting the appropriate box. Disclosing entity may require proof of authority of the representative.

RESET FORM

OHIO STANDARD HIPAA AUTHORIZATION FORM

Fields marked with an asterisk (*) are required to be completed. Failure to provide additional identifying information in Section I may result in the inability to respond to this request. This form is not a patient access request under 45 CFR 164.524. *Records released pursuant to this authorization may include information concerning testing, diagnosis or treatment of HIV/AIDS, psychiatric and/or drug/alcohol treatment, and/or sexual assault.*

FORM A – AUTHORIZATION FOR RELEASE OF INFORMATION FROM COVERED ENTITIES (OTHER THAN PART 2 PROGRAMS)

Section I

First Name*	M.I.	Last Name*	Date of Birth*	Social Security Number

Address	City	State	Zip Code

I hereby authorize the disclosure of health information about the above individual as follows.

Section II

Disclosing Entity* *(Covered Entity such as a health plan/insurer or provider)*

Address	Telephone Number

City	State	Zip Code

Recipient (Person or Entity)*

Contact Information *(e.g. telephone number, email address, fax number, street address, etc.)*

Section III

Reason for Disclosure*

Health information to be disclosed*

Specify time period, if desired:
Release only information from the period _____ *(mm/dd/yyyy)* to _____ *(mm/dd/yyyy)*

Section IV

This authorization will remain in effect until revoked or shall expire on date or event specified below. I understand that I may revoke or cancel this authorization at any time by submitting written revocation in the manner specified by the disclosing entity, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will expire on the date or completion of the event stated below. If no date or event is specified below, this authorization will expire in one year.

Expiration Date or Event

- I understand that I may not be denied treatment, payment, and enrollment in the health plan, or eligibility for benefits for refusing to authorize disclosure unless such denial is permitted under state and federal law.
- I understand that information disclosed by this authorization, except as prohibited by 42 CFR Part 2 or other applicable law, may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164].

Signature of Individual*	Date* *(mm/dd/yyyy)*

Signature of Personal Representative (if applicable)* *(identify relationship to individual below)*	Date* *(mm/dd/yyyy)*

Relationship of Personal Representative to Individual (*Personal representative shall submit proof of authority to the disclosing entity)*
☐ Parent ☐ Legal Guardian ☐ Healthcare Power of Attorney ☐ Executor/Administrator ☐ Other ☐ N/A

For administrative use only:

Method of Delivery (e.g. paper, fax, electronic,)	Date Released

FORM B – CONSENT FOR RELEASE OF PART 2 PROGRAM (SUBSTANCE USE DISORDER PROVIDER) INFORMATION

A Part 2 Program is a federally assisted: (i) individual or entity other than a general medical facility who holds itself out as providing, and provides, substance use disorder (SUD) diagnosis, treatment, or referral for treatment; (ii) an identified unit within a general medical facility that holds itself out as providing, and provides, SUD diagnosis, treatment, or referral for treatment; or, (iii) medical personnel or staff in a general medical facility whose primary function is provision of SUD diagnosis, treatment, or referral for treatment, and who are identified as such providers.

Section I

First Name*	**M.I.**	**Last Name***	**Date of Birth***	**Social Security Number**	
Address			**City**	**State**	**Zip Code**

I hereby authorize the disclosure of health information about the above individual as follows.

Section II

Disclosing Entity* *(Name of Holder of Part 2 Program Information)*		**Telephone Number**	
Address	**City**	**State**	**Zip Code**

The information is to be provided to the following*:

☐ Named Individual:
☐ Named Third Party Payer:
☐ Named Treatment Provider Entity:
☐ Named Non-Treatment Provider (such as an intermediary or research entity)[+]:

[+]*If non-treatment provider is selected complete a, b and/or c below.*

a. Named Individual Participant(s):
b. Named Treatment Provider Entity Participant(s):
c. Description of Group or Class of Treatment Provider Entity Participant(s):

Contact Information (e.g. telephone number, email address, fax number, street address, etc.)

Section III

Reason for Disclosure*	**Health information to be disclosed***:

Specify time period, if desired:

Release only information from the period _____ *(mm/dd/yyyy)* to _____ *(mm/dd/yyyy)*

Section IV

This authorization will remain in effect until revoked or shall expire on date or event specified below. I understand that I may revoke or cancel this authorization at any time by submitting written revocation in the manner specified by the disclosing entity, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will expire on the date or completion of the event stated below. If no date or event is specified below, this authorization will expire in one year.

Expiration Date or Event

- Substance use disorder records of Part 2 programs disclosed pursuant to this Consent are protected by federal regulations and cannot be re-disclosed without my written consent unless otherwise provided for in the regulations. Any information disclosed pursuant to this Consent other than substance use disorder records or records protected under another state law may be subject to re-disclosure by the recipient.
- I might be denied services if I refuse to authorize disclosure of information for purposes of assessment, treatment, or payment relating to substance use disorder if refusal is permitted by state law. My refusal to authorize disclosure of information for other purposes will not affect my ability to obtain treatment or services.
- If I have authorized disclosure to a generally described group or class of participants in an entity which is not my treatment provider, upon my written request, I must be provided a list of entities to which my information has been disclosed pursuant to that general designation.

Signature of Individual*	**Date*** *(mm/dd/yyyy)*
Signature of Personal Representative (if applicable)* *(identify relationship to individual below)*	**Date*** *(mm/dd/yyyy)*

Relationship of Personal Representative to Individual (*Personal representative shall submit proof of authority to the disclosing entity)*

☐ Parent ☐ Legal Guardian ☐ Healthcare Power of Attorney ☐ Executor/Administrator ☐ Other ☐ N/A

For administrative use only:

Method of Delivery (e.g. paper, fax, electronic)	**Date Released**