

Hawaii: Advance Directive



NOTE: This form is being provided to you as a public service. The attached forms are provided “as is” and are not the substitute for the advice of an attorney. By providing these forms and information, Everplans is not providing legal advice to you. Consult an attorney if you need legal advice of any nature.

Read more and get more forms at Everplans’ [Advance Directive](#) page.

HAWAI‘I ADVANCE HEALTH CARE DIRECTIVE

My name is:

Last

First

Middle initial

Date of Birth

Date

PART 1: HEALTH CARE POWER OF ATTORNEY – DESIGNATION OF AGENT:

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

Name and relationship of individual designated as health care agent

Street Address City State Zip

Home Phone Cell Phone E-mail

If I revoke my agent’s authority or if my agent is not willing, able, or reasonably available to make decisions for me, I designate the following individual as my alternate agent:

Name and relationship of individual designated as health care agent

Street Address City State Zip

Home Phone Cell Phone E-mail

AGENT’S AUTHORITY AND OBLIGATION:

My healthcare agent should make decisions as I have instructed in Part 2 of this form or as I may otherwise provide orally or in writing. If there are decisions for which I have not provided instructions, I want my agent to make such decisions as I would have chosen to do, basing them on my values, goals, and preferences rather than those of my agent. If a guardian of my person needs to be appointed for me by a court, I nominate my agent.

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 unless I mark the following box.

- If I mark this box, my agent’s authority to make health care decisions for me takes effect immediately. However, I always retain the right to make my own decisions about my health care. I can revoke this authority at any time as long as I have mental capacity.

PART 2: INDIVIDUAL INSTRUCTIONS (You may modify or strike through anything with which you do not agree. Initial and date any modifications.)

A. END OF LIFE DECISIONS

- If I have an incurable and irreversible condition that will result in my death within a relatively short time, OR
- If I have lost the ability to communicate my wishes regarding my health care and it is unlikely that I will ever recover that ability, OR
- If the likely risks and burdens of treatment would outweigh the expected benefits.

THEN 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: Check only one of the following boxes. You may also initial your selection.

I want to stop or withhold medical treatment that would prolong my life.

OR

I want medical treatment that would prolong my life as long as possible within the limits of generally accepted health care standards.

YOUR NAME:

Print Your Full Name

Date of Birth

Date

PART 2: INDIVIDUAL INSTRUCTIONS (CONTINUED) (You may modify or strike through anything with which you do not agree. Initial and date any modifications.)

B. ARTIFICIAL NUTRITION AND HYDRATION - FOOD AND FLUIDS:

Artificial nutrition and hydration must be provided, withheld or withdrawn in accordance with the choice I have made in the preceding paragraph A unless I mark the following box.

If I mark this box, artificial nutrition and hydration must be provided under all circumstances as long as it is within the limits of generally accepted healthcare standards.

C. RELIEF FROM PAIN:

If I mark this box, I choose treatment to alleviate pain or discomfort even if it might hasten my death.

D. OTHER

If I mark this box, the additional instructions or information I have attached are to be incorporated into my care. (Sign and date each added page and attach to this form.)

E. WHAT IS IMPORTANT TO ME: (Optional. Add additional sheets if needed.) The things that I value and that make life worth living to me are: (examples: gardening, walking my pet, shopping, participating in family gatherings, attending church or temple):

I have attached _____ additional sheet/s

My thoughts about when I would not want my life prolonged by medical treatment (Examples include: If I no longer have the mental capacity to make my own decisions, if I have lost all ability to communicate, if I can no longer safely swallow, etc):

I have attached _____ additional sheet/s

YOUR NAME: (Please sign in front of witnesses or notary public)

Print Your Full Name

Your Signature

Date of Birth

Date

WITNESSES: CHOOSE EITHER OPTION 1 OR 2, NOT BOTH.

Important: Witnesses cannot be your health care agent, a health care provider or an employee of a health care facility. One witness cannot be a relative or have inheritance rights.

OPTION 1: WITNESSES

I (Witness 1) declare that the person completing this advance health care directive is personally known to me, that she/he signed or acknowledged this power of attorney in my presence and appears to be of sound mind and under no undue influence. I am not related by blood, marriage, or adoption, and to the best of my knowledge I am not entitled to any part of her/his estate. I am not the person appointed as agent by this document, and I am not a health-care provider, nor an employee of a health-care provider or facility.

Witness #1 Print Name

Witness Signature

Date

Street Address

City

State Zip

I (Witness 2) declare that the person completing this advance health care directive is personally known to me, that she/he signed or acknowledged this power of attorney in my presence and appears to be of sound mind and under no undue influence. I am not the person appointed as agent by this document, and I am not a health-care provider, nor an employee of a health-care provider or facility.

Witness #2 Print Name

Witness Signature

Date

Street Address

City

State Zip

OPTION 2: NOTARY PUBLIC

State Hawai'i, } ss.
 (City and) County of _____

On this _____ day of _____, in the year _____, before me,
 _____, (insert name of notary public) appeared
 _____, personally known to me (or proved to me
 on the basis of satisfactory evidence) to be the person whose name is subscribed to this ___-page Hawai'i
 Advance Health Care Directive dated on _____, in the _____ Judicial Circuit of
 the State of Hawai'i, and acknowledged that he/she executed the same as his/her free act and deed.

Signature of Notary Public

My Commission Expires: _____

A copy has the same effect as the original.
www.kokuamau.org/resources/advance-directives
 Developed by the Executive Office on Aging and
 Kōkua Mau - Hawai'i Hospice and Palliative Care Organization

Place Notary Seal or Stamp Above

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Share and discuss your Advance Health Care Directive with your doctor, loved ones and agent

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