Maryland Advance Directive

Planning for future health care decisions

State of Maryland, Office of the Attorney General. Accessible text based version prepared from the May 2024 form and booklet.

Letter to Marylanders

The form is optional. You may use it if you want or use another form that is also legally valid. If you have legal questions about your personal situation, consult your own lawyer. If you decide to make an advance directive, talk about it with those close to you. The conversation is just as important as the document. Give copies to family members or friends and your doctor, and bring a copy if you go into a hospital. Do not return completed forms to the Office of the Attorney General.

Life threatening illness is a difficult subject. Planning now helps ensure that your choices can be respected and can relieve at least some of the burden on loved ones in the future. You may also use the enclosed After My Death form to make an organ donation or plan for arrangements after death.

- For information about Do Not Resuscitate orders, visit marylandmolst.org or contact the Maryland Institute for Emergency Medical Services Systems at 410 706 4367. The MOLST form contains medical orders regarding cardiopulmonary resuscitation and other life sustaining treatments. A physician, nurse practitioner, or physician assistant may use a MOLST form to instruct emergency medical personnel to provide comfort care instead of resuscitation.
- The Maryland Department of Health also makes available an advance directive focused on preferences about mental health treatment through its forms page.
- Additional information about advance directives can be found at health.maryland.gov advance directives.

Health care planning using advance directives

Adults can decide for themselves whether they want medical treatment. This right applies to treatments that extend life, such as a breathing machine or feeding tube. Accident or illness can take away a person's ability to make health care decisions, but decisions still have to be made. If you cannot do so, someone else will. These decisions should reflect your values and priorities.

A Maryland law called the Health Care Decisions Act says that you can do health care planning through advance directives. An advance directive can name a health care agent and can state your preferences about treatments that might be used to sustain your life.

The State offers a form for this planning. The form has three parts. Part I is Selection of Health Care Agent. Part II is Treatment Preferences or Living Will. Part III is Signature and Witnesses.

The advance directive is meant to reflect your preferences. You may complete all of it, or only part of it, and you may change the wording. Different forms may also be used. Once you make an advance directive, it remains in effect unless you revoke it. It does not expire, and no one except you can change it while you have decision making capacity.

Frequently asked questions

Must I use any particular form. No. An optional form is provided, but you may change it or use a different form altogether.

Who can be picked as a health care agent. Anyone who is 18 or older except, in general, an owner, operator, or employee of a health care facility where a patient is receiving care.

Who can witness an advance directive. Two witnesses are needed. Generally, any competent adult can be a witness. If you name a health care agent, that person cannot be a witness. One witness also must not knowingly inherit from you or otherwise gain a financial benefit from your death.

Do the forms have to be notarized. No.

Do these documents deal with financial matters. No. Talk with a lawyer if you want to plan for financial matters in case of incapacity.

Are these forms valid in another state. It depends on the law of the other state. Most state laws recognize advance directives made somewhere else.

How can I get forms for another state. Contact the National Hospice and Palliative Care Organization or review resources on caringinfo.

How should I show the choices I have made. Write your initials next to the statement that says what you want. Do not use checkmarks or X marks. You may also draw lines through statements you do not want.

Can my doctor override my living will. Usually no, although a doctor is not required to provide medically ineffective treatment.

To whom should I give copies. Give copies to your doctor, your health care agent and backup agents, any hospital or nursing home where you will be staying, and family members or friends who should know your wishes.

Maryland advance directive form

By _____

Date of birth _____

Using this advance directive form is completely optional. Other forms are also valid in Maryland. No matter what form you use, talk to your family and others close to you about your wishes.

This form has two parts to state your wishes and a third part for signatures. You can complete Part I and Part II, only Part I, or only Part II. Sign in front of two witnesses. If your wishes change, make a new advance directive and share updated copies with your agent, your doctor, and others who may need it.

Part I Selection of health care agent

A. Selection of primary agent

Name _____

Address _____

Telephone numbers home and cell _____

B. Selection of backup agents

This section is optional. The form is valid if left blank.

First backup agent name _____

First backup agent address _____

First backup agent telephone numbers home and cell _____

Second backup agent name _____

Second backup agent address _____

Second backup agent telephone numbers home and cell

_____

C. Powers and rights of health care agent

I want my agent to have full power to make health care decisions for me, including the power to do the following.

1. Consent or not to medical procedures and treatments offered by my doctors, including interventions intended to keep me alive, such as ventilators and feeding tubes.
2. Decide who my doctor and other health care providers should be.
3. Decide where I should be treated, including whether I should be in a hospital, nursing home, other medical care facility, or hospice program.
4. Ride with me in an ambulance if I need to be rushed to the hospital and be able to visit me in a hospital or other health care facility.

This advance directive does not make my agent responsible for any of the costs of my care.

Conditions or limitations on my agent's power

_____

D. How my agent is to decide specific issues

My agent should look first to Part II of this advance directive, then consider our conversations, my religious and other beliefs and values, my personality, and how I handled important issues in the past. If my wishes are still unclear, my agent should make decisions based on my best interests, considering the benefits, burdens, and risks of the choices presented by my doctors.

E. People my agent should consult

Names _____

Telephone numbers _____

F. In case of pregnancy

Instructions _____

G. Access to my health information

- Before my agent has power to act, I authorize my doctor to disclose protected health information related to my capacity to make my own decisions if my doctor wants to discuss that issue with my agent.
- Once my agent has full power to act, my agent may request, receive, and review information regarding my physical or mental health, including medical and hospital records and other protected health information, and consent to disclosure of this information.
- For all purposes related to this document, my agent is my personal representative under HIPAA and may sign related release forms or materials.

H. Effectiveness of this part

Initial one only.

Option 1 My agent's power is in effect immediately after I sign this document, subject to my right to make any decision about my health care if I want and am able to. Initials _____

Option 2 My agent's power is in effect whenever I am not able to make informed decisions about my health care, either because my attending physician decides I have lost this ability temporarily, or because my attending physician and a consulting doctor agree that I have lost this ability permanently. Initials _____

Part II Treatment preferences living will

A. Statement of goals and values

Goals and values _____

B. Preference in case of terminal condition

If my doctors certify that my death from a terminal condition is imminent, even if life sustaining procedures are used

Initial one only unless you choose to cross through the entire section.

5. Keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means. Initials _____
6. Keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means. Initials _____
7. Try to extend my life for as long as possible using all available interventions that in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical means. Initials _____

C. Preference in case of persistent vegetative state

If my doctors certify that I am in a persistent vegetative state and there is no reasonable expectation that I will ever regain consciousness

Initial one only unless you choose to cross through the entire section.

8. Keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means. Initials _____
9. Keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means. Initials _____
10. Try to extend my life for as long as possible using all available interventions that in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical means. Initials _____

D. Preference in case of end stage condition

If my doctors certify that I am in an incurable end stage condition that has resulted in loss of capacity and complete physical dependency

Initial one only unless you choose to cross through the entire section.

11. Keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means. Initials _____
12. Keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means. Initials _____
13. Try to extend my life for as long as possible using all available interventions that in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical means. Initials _____

E. Pain relief

No matter what my condition, give me the medicine or other treatment I need to relieve pain.

F. In case of pregnancy

Modified instructions _____

G. Effect of stated preferences

Initial one only.

Option 1 My stated preferences are meant to guide whoever is making decisions on my behalf and my health care providers, but they may be flexible in applying these statements if they feel that doing so would be in my best interest. Initials _____

Option 2 I want whoever is making decisions on my behalf and my health care providers to follow my stated preferences exactly as written, even if they think some alternative is better. Initials _____

Part III Signature and witnesses

By signing below as the declarant, I indicate that I am emotionally and mentally competent to make this advance directive and that I understand its purpose and effect. I also understand that this document replaces any similar advance directive I may have completed before this date.

Signature of declarant _____

Date _____

The declarant signed or acknowledged signing this document in my presence and, based upon personal observation, appears to be emotionally and mentally competent to make this advance directive.

Signature of witness 1 _____

Date for witness 1 _____

Telephone numbers for witness 1 _____

Signature of witness 2 _____

Date for witness 2 _____

Telephone numbers for witness 2 _____

Anyone selected as a health care agent in Part I may not be a witness. At least one witness must be someone who will not knowingly inherit anything from the declarant or otherwise knowingly gain a financial benefit from the declarant's death. Maryland law does not require this document to be notarized.

After My Death form

This document is optional. Complete only what reflects your wishes.

By _____

Date of birth _____

Part I Organ donation

Initial the items you want and cross through any that you do not want.

- ☐ Any needed organs, tissues, or eyes

Only the following organs, tissues, or eyes _____

- ☐ For transplantation
- ☐ For therapy
- ☐ For research
- ☐ For medical education
- ☐ For any purpose authorized by law

I understand that no vital organ, tissue, or eye may be removed for transplantation until after I have been pronounced dead. This document is not intended to change anything about my health care while I am still alive. After death, I authorize any appropriate support measures needed to maintain the viability of organs, tissues, and eyes until recovery has been completed. I understand that my estate will not be charged for costs related to this donation.

Part II Donation of body

After any organ donation indicated in Part I, I wish my body to be donated for use in a medical study program. Initials _____

Part III Disposition of body and funeral arrangements

I want the following person to make decisions about the disposition of my body and my funeral arrangements.

Option 1 The health care agent named in my advance directive. Initials _____

Option 2 This person.

Name _____

Address _____

Telephone numbers home and cell _____

My wishes about disposition of my body and funeral arrangements

_____

Part IV Signature and witnesses

Signature of donor _____

Date _____

Signature of witness 1 _____

Date for witness 1 _____

Telephone numbers for witness 1 _____

Signature of witness 2 _____

Date for witness 2 _____

Telephone numbers for witness 2 _____

Body donation program note

The State Anatomy Board, a unit of the Department of Health, administers a statewide body donation program. Anatomical donation allows individuals to dedicate the use of their bodies after death to advance medical education, clinical and allied health training, and research study in Maryland medical study institutions.

If you complete the donation of body section and wish to donate your body to the State Anatomy Board, you must also complete the State Anatomy Board donor forms. For information and forms, visit the State Anatomy Board website or call 800 879 2728.

Final checklist

- ☐ Fill out Part I if you want to name a health care agent
- ☐ Name one or two backup agents in case your first choice is not available when needed
- ☐ Talk to your agents about your values and priorities and decide whether you also want to make specific health care decisions in the advance directive
- ☐ If you want to make specific decisions, fill out Part II carefully
- ☐ Sign and date the advance directive in front of two witnesses who also sign
- ☐ Review the After My Death form to see whether you want to complete any part of it
- ☐ Make sure your health care agent, your family, and your doctor know about your advance care planning
- ☐ Give a copy of your advance directive to your health care agent, family members, doctor, and any hospital or nursing home where you are a patient