Medical Directives/Care & Consent

This sample is being provided to help facilitate your advanced planning. We are not providing legal advice and encourage review by a competent advisor.

Statement of My Intent

This is a statement to my agent named in my Healthcare Power of Attorney reflecting my current choices for care. The medical staff shall have immunity from liability for complying with any choice (by me or my agent) that is in conflict with the medical standard of care or the medical staff's opinion of care.

Although it is my agent under my Healthcare Power of Attorney that has the authority to make decisions for me and express my choices, this statement will also communicate to medical facilities and providers my strong opinions regarding care and the importance to me of the autonomy of the patient. This document also reflects my deeply held Biblical beliefs. I ask my agent to please ensure that this document is clearly accessible in electronic medical records at all times for all of my care providers.

MY CAREFULLY PLANNED AND INTENTIONAL WISHES THAT ARE BASED UPON MY DEEPLY HELD BIBLICAL BELIEFS INCLUDE:

1. I REQUEST AND CONSENT to an advocate, chosen by me, to be in the room with me at all times, regardless of facility policy.
2. I REQUEST AND CONSENT that all of the information in this document be entered into my electronic medical records, so it is plainly visible to all medical staff.
3. I DO NOT CONSENT TO THE USE OF MEDICATIONS WITHOUT MY BEING INFORMED OF EACH MEDICATION'S RISKS, BENEFITS, AND ALTERNATIVES BEFORE THEY ARE ORDERED. Only after that information is communicated shall I choose to either grant consent or not grant consent for each and every medication that is ordered. Individual consent is needed for each medication and changes in dosages. Consent to a medication at one time does not provide blanket consent for use of that same medication in the future if it is discontinued. Separate consent must be obtained by me for reintroducing a medication. My agent is also able to communicate separate consent on my behalf per the terms of my Healthcare Power of Attorney.
4. I DO NOT CONSENT to receiving any vaccine or booster for ANY purpose or disease. My agent under my Healthcare Power of Attorney is authorized to enforce this statement on my behalf.
5. I DO NOT CONSENT to a ventilator WITHOUT consultation with myself or with my agent under my Healthcare Power of attorney on my behalf regarding the risks, benefits, and alternatives PRIOR to the implementation of the ventilator. Only AFTER that information is communicated to me shall I, or my agent, choose to either grant consent or to not grant consent for the ventilator.
6. I DO NOT CONSENT to protocols, standards of care, or treatment plans without first conducting an independent evaluation regarding side effects and risks associated with each. Under no circumstances should any protocol, standard of care, or treatment plan be initiated without my specific approval for each aspect of protocol or treatment plan. My agent is also able to communicate consent on my behalf per the terms of my Healthcare Power of Attorney.
7. I REQUEST AND CONSENT to the use of all life-saving measures, such as CPR and all other resuscitation measures. If I consent to my discharge to hospice level of care, I REQUEST AND CONSENT that I be provided adequate oxygen, nutrition, hydration, medication, and any other

equipment necessary for comfort. My agent is also able to communicate consent on my behalf per the terms of my Healthcare Power of Attorney. A Do Not Resuscitate order shall NOT be entered into any medical records without my, or my Healthcare Power of Attorney's express written consent.

8. I DO NOT CONSENT to receiving ANY blood transfusions without first verifying that the transfusion would not introduce any elements to my body that I have chosen to refuse. My agent is also able to communicate consent on my behalf per the terms of my Healthcare Power of Attorney. I am a member of Blessed by His Blood Cooperative, and they may be reached at membership@blessedbyhisblood.com.
9. I REQUEST AND CONSENT to the use of all alternative treatments available, whether or not they are covered by insurance or are the standard of care. My agent is also able to communicate consent on my behalf per the terms of my Healthcare Power of Attorney.
10. I DO NOT CONSENT to receiving ANY processed food, such as high-fructose corn syrup or seed oils. The only acceptable oil for me is butter, ghee, beef tallow, or coconut oil. Acceptable forms of protein are eggs, lamb, bison, beef, or non-farmed seafood; but they must not be prepared with seed oils. If the hospital is unable to provide this food for me, my family or friends will bring it for me.
11. I DO NOT CONSENT to myself, my treatment, or my body being used for training purposes for any reason.
12. I DO NOT CONSENT to the donation of any of my organs, any fluid from or created by my body, or any part of my body.
13. I DO NOT CONSENT to any video or audio recording by the medical facility and/or medical staff for any reason.
14. I DO NOT CONSENT to the medical facility's use of live action video or audio being transmitted, even internally to other departments or other areas of the medical facility, even if the video or audio is not being recorded.
15. I DO NOT CONSENT to any of the decisions or prohibitions I have communicated myself, communicated in this document, or communicated through my agent named in my Healthcare Power of Attorney to be overridden by or ignored due to an emergency I may have, any state of emergency issued by a governmental or private agency, including a Public Health Emergency, or any argument of medical necessity. Should my healthcare Power of Attorney be unavailable, for whatever reason, my clear intentions have been made in this document.

NOTICE

If I am unable to personally provide my Healthcare Power of Attorney document, including any Care & Consent Attachment, my agent named in my Healthcare Power of Attorney must and will provide copies of my Healthcare Power of Attorney, HIPAA Authorizations, and all attachments thereto on my behalf to any hospital, doctor's office, and/or medical or long-term care facility where I may be treated, to any medical professionals, such as doctors, nurses, physician's assistants, etc. who may be providing me with medical treatment, medication, recommendations, etc., and to any administrative agency involved in managing any hospital, doctor's office, and/or medical or long-term care facility where I may be treated or overseeing any medical professionals involved with me or my care. My agent must and will present this document to any medical facility where I am a patient or any location where I am being medically treated, even if I have been treated previously at that location. Additionally, while I am a patient at any

medical facility, my agent must and will make every reasonable attempt to provide a copy of this document to my attending physician, to any nurse providing me with care, and to any other person involved in my care and/or the coordination of my care. This document supersedes any document used for the purpose of admitting me to any medical facility, whether signed by me, or any other person.

VIOLATION

For each and every violation of any provision of this document or of my intentions under this document as interpreted by my agent under my Medical Power of Attorney, my agent will take any and all steps necessary to enforce this document and my intentions. I also strongly encourage my agent to initiate action in a court or other relevant governing body to enforce each provision and hold any violators accountable, including punitive, and criminal, measures. Finally, any violation, subject to my agent's sole and absolute discretion, will result in an immediate report to the medical board, and my agent should file suit in court to compel any medical facility and/or medical personnel to adhere to the terms of this document. Again, my agent must and will also pursue any punitive, and criminal, measure available. My agent is directed to use all resources available, in conjunction with my Financial Power of attorney, to facilitate this request.

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Name Date