

# *The Halachic Medical Directive*

## *PROXY AND DIRECTIVE WITH RESPECT TO HEALTH CARE DECISIONS AND POST-MORTEM DECISIONS*

### *FOR USE IN CONNECTICUT*

The “Halachic Medical Directive” is designed to help ensure that all medical and post-death decisions made by others on your behalf will be made in accordance with Jewish law and custom (*halacha*). The text of this Halachic Medical Directive has been approved by attorneys for use in your state as of November, 2003. While we do not expect that any future change in federal or state laws would materially affect the validity of this document, you may wish to show it to your own attorney to confirm its effectiveness in subsequent years. You must be an individual 18 years of age or older who is of sound mind at the time you execute this document.

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### INSTRUCTIONS

1. **Please print your name on the first line of the form.**
2. **In Section 1, print the name, address, and telephone numbers of the person you wish to designate as your health care agent** (“agent”) to make medical decisions on your behalf if, G-d forbid, you ever become incapable of making them on your own. Be sure to include all numbers (including cell phone and pager) where your agent can be reached in the event of an emergency. If the contact information for your agent changes, you should provide that updated information to everyone whom you have provided with a copy of your Halachic Medical Directive.

**You may also insert the name, address, and telephone numbers of an alternate agent** to make such decisions if your main agent is unable, unwilling, or unavailable to make such decisions.

It is recommended that before appointing anyone to serve as your agent or alternate agent you should ascertain that person’s willingness to serve in such capacity. In addition, if you have made arrangements with a burial society (Chevra Kadisha), you may wish to advise your agent of such arrangements.

Note: *Connecticut law allows virtually any competent adult* (an adult is a person 18 years of age or older) *to serve as an agent*. Thus, you may appoint as your agent (or alternate agent) your spouse, adult child, parent or other adult relative. You may also appoint a non-relative to serve as your agent (or alternate agent) *except you may not appoint an operator, administrator or employee of any health care facility or residential care home currently treating you or where you currently reside or to which you have applied for admission*. Further, an administrator or employee of a government agency that is financially responsible for your medical care may not act as your agent. You may appoint your physician as your agent, however, under Connecticut law he or she cannot act as both your representative and your attending physician at the same time, so appointing your physician is not recommended.

3. **In section 3, please print the name, address, and telephone numbers of the Orthodox Rabbi whose guidance you want your agent to follow**, should any questions arise as to the requirements of *halacha*.

**You should then print the name, address, and telephone numbers of the Orthodox Jewish institution or organization you want your agent to contact for a referral to another Orthodox Rabbi if**

the rabbi you have identified is unable, unwilling or unavailable to provide the appropriate consultation and guidance.

You are, of course, free to insert the name of any Orthodox Rabbi or institution/organization you would like, but before doing so it is advisable to discuss the matter with the rabbi or institution/organization to ascertain their competency and willingness to serve in such capacity. You may list Agudath Isreal of America as the organization you select, however we are only available to be contacted on regular business hours and days.

**4. In Section 8, sign and print your name, address, phone numbers, and the date before two witnesses.** The two witnesses must be competent adults and neither one may be the person you have appointed as your agent (or alternate agent).

PLEASE NOTE: If you reside in a mental health facility operated or licensed by the Department of Mental Health and Addiction Services, at least one of the witnesses must be an individual who *is not* affiliated with the facility and at least one of the witnesses must be a physician or clinical psychologist with specialized training in treating mental illness. If you reside in a mental health facility operated or licensed by the Department of Mental Retardation, at least one witness must be an individual who *is not* affiliated with the facility and at least one witness must be a physician or clinical psychologist with specialized training in developmental disabilities.

**5. In the DECLARATION OF WITNESSES Section, the date should be inserted in the declaration and the two witnesses should sign their names, attesting to the contents of the declaration, and print their addresses beneath their signature.**

6. It is recommended that you keep the original of this form among your valuable papers in a location that is readily accessible in the event of an emergency; and that you **distribute copies to the agent (and alternate agent)** you have designated in section 1, **to the rabbi and institution/organization** you have designated in section 3, as well as to **your doctors, your lawyer**, and anyone else who is likely to be contacted in times of emergency. We also recommend that you register a copy of this form with a national registry, so that it can be accessed by any health care facility via computer. This can be done for a fee by contacting the U.S. Living Will Registry at <http://www.uslivingwillregistry.com/> or by calling 1-800-548-9455.

**7. Please note that this document is effective immediately for the purpose of expressing your wish that Jewish law govern your health care decisions. Before an agent may exercise powers concerning your custody, care and medical treatment, (i) a copy of this Proxy and Directive must be given to your attending physician and (ii) the attending physician must make a determination that you are incapacitated.**

**8. If at any time you wish to revoke this Proxy and Directive, you may do so by indicating your intent to revoke it in any manner.** To avoid possible confusion, it would be wise to try to obtain all originals and copies of the old Proxy and Directive and destroy them. An appointment of your spouse as your agent (or alternate care agent) is automatically revoked upon divorce or legal separation, unless you specify otherwise.

If you do not revoke the Proxy and Directive, Connecticut law provides that it remains in effect indefinitely. Obviously, if any of the persons you have appointed in the Proxy and Directive dies or becomes otherwise incapable of serving in the role you have assigned, it would be wise to execute a new Proxy and Directive.

9. It is recommended that you also complete and cut out the **Emergency Instructions Card** contained on the last page of this Halachic Medical Directive and carry it with you in your wallet or purse.

10. If, upon consultation with your rabbi, you would like to add to this standardized Proxy and Directive any additional expression of your wishes with respect to medical and/or post-mortem decisions, you may do so by attaching a “rider” to the standardized form. If you choose to do so, or if you have any other questions concerning this form, please consult an attorney.

These instructions are not part of the Halachic Medical Directive and need not be  
kept attached to the executed document.

***PROXY AND DIRECTIVE  
WITH RESPECT TO HEALTH CARE DECISIONS  
AND POST-MORTEM DECISIONS***

***FOR USE IN CONNECTICUT***

I, \_\_\_\_\_, hereby declare as follows:

**1. Appointment of Agent:** In recognition of the fact that there may come a time when I will become unable to make my own health care decisions because of illness, injury or other circumstances, I, after careful reflection, while I am of sound mind, hereby appoint

*Agent*

Name of Agent:  
\_\_\_\_\_

Address:  
\_\_\_\_\_

Telephone: Day: \_\_\_\_\_

Evening: \_\_\_\_\_

Cell: \_\_\_\_\_

Pager/beeper: \_\_\_\_\_

as my health care agent (“agent”) to make any and all health care decisions for me, consistent with my wishes as set forth in this directive.

If the person named above is unable, unwilling or unavailable to act as my agent, I hereby appoint:

*Alternate  
Agent*

Name of Alternate Agent:  
\_\_\_\_\_

Address:  
\_\_\_\_\_

Telephone: Day: \_\_\_\_\_

Evening: \_\_\_\_\_

Cell: \_\_\_\_\_

Pager/beeper: \_\_\_\_\_

to serve in such capacity.

This appointment shall take effect in the event I become unable, because of illness, injury or other circumstances, to make my own health care decisions.

**2. Jewish Law to Govern Health Care Decisions:** I am Jewish. It is my desire, and I hereby direct, that all health care decisions made for me (whether made by my agent, a guardian appointed for me, or any other person) be made pursuant to Jewish law and custom as determined in accordance with strict Orthodox interpretation and tradition. Without limiting in any way the generality of the foregoing, it is my wish that Jewish law and custom should dictate the course of my health care with respect to such matters as the

performance of cardio-pulmonary resuscitation if I suffer cardiac or respiratory arrest; the performance of life-sustaining surgical procedures and the initiation or maintenance of any particular course of life-sustaining medical treatment or other form of life-support maintenance, including the provision of nutrition and hydration; and the criteria by which death shall be determined, including the method by which such criteria shall be medically ascertained or confirmed.

**3. Ascertaining the Requirements of Jewish Law:** In determining the requirements of Jewish law and custom in connection with this declaration, I direct my agent to consult with the following Orthodox Rabbi and I ask my agent to follow his guidance:

*Rabbi* Name of Rabbi: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone: Day: \_\_\_\_\_ Evening: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_ Pager/beeper: \_\_\_\_\_

If such Orthodox Rabbi is unable, unwilling or unavailable to provide such consultation and guidance, then I direct my agent to consult with, and I ask my agent to follow the guidance of, the following Orthodox Rabbi:

*Rabbi* Name of Rabbi: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone: Day: \_\_\_\_\_ Evening: \_\_\_\_\_  
Cell: \_\_\_\_\_ Pager/beeper: \_\_\_\_\_

If both of these Orthodox Rabbis are unable, unwilling or unavailable to provide such consultation and guidance, then I direct my agent to consult with, and I ask my agent to follow the guidance of, an Orthodox Rabbi referred by the following Orthodox Jewish institution or organization:

*Organization* Name of Institution/Organization: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone: Day: \_\_\_\_\_ Evening: \_\_\_\_\_

If such institution or organization is unable, unwilling or unavailable to make such a reference, or if the Orthodox Rabbi referred by such institution or organization is unable, unwilling or unavailable to provide such guidance, then I direct my agent to consult with, and I ask my agent to follow the guidance of, an Orthodox Rabbi whose guidance on issues of Jewish law and custom my agent in good faith believes I would respect and follow.

**4. Direction to Health Care Providers:** Any health care provider shall rely upon and carry out the decisions of my agent, and may assume that such decisions reflect my wishes and were arrived at in accordance with the procedures set forth in this directive, unless such health care provider shall have good cause to believe that my agent has not acted in good faith in accordance with my wishes as expressed in this directive.

If the persons designated in section 1 above as my agent and alternate agent are unable, unwilling or unavailable to serve in such capacity, it is my desire, and I hereby direct, that any health care provider or other person who will be making health care decisions on my behalf follow the procedures outlined in section 3 above in determining the requirements of Jewish law and custom.

Pending contact with the agent and/or Orthodox Rabbi described above, it is my desire, and I hereby direct, that all health care providers undertake all essential emergency and/or life sustaining measures on my behalf.

**5. Access to Medical Records and Information; HIPAA:** My agent is my personal representative, as such term is defined under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), and accordingly all of my protected health information (as such term is defined under HIPAA) and other medical records shall be made available to my agent upon request in the same manner as such information and records would be released and disclosed to me, and my agent shall have and may exercise all of the rights I would have regarding the use and disclosure of such information and records, as required under HIPAA.

**6. Post-Mortem Decisions:** It is also my desire, and I hereby direct, that after my death, all decisions concerning the handling and disposition of my body be made pursuant to Jewish law and custom as determined in accordance with strict Orthodox interpretation and tradition. For example, Jewish law generally requires expeditious burial and imposes special requirements with regard to the preparation of the body for burial. It is my wish that Jewish law and custom be followed with respect to these matters. I hereby willfully and voluntarily make known my desire that, in the event of my death, the disposition of my remains shall be controlled by my agent designated in section 1 above. In the event my agent is unable, unwilling or unavailable to act, I hereby appoint the alternate agent designated in section 1 above to control the disposition of my remains.

Further, subject to certain limited exceptions, Jewish law generally prohibits the performance of any autopsy or dissection. It is my wish that Jewish law and custom be followed with respect to such procedures, and with respect to all other post-mortem matters including the removal and usage of any of my body organs or tissue for transplantation or any other purposes. I direct that any health care provider in attendance at my death notify the agent and/or Orthodox Rabbi described above immediately upon my death, in addition to any other person whose consent by law must be solicited and obtained, prior to the use of any part of my body as an anatomical gift, so that appropriate decisions and arrangements can be made in accordance with my wishes. Pending such notification, and unless there is specific authorization by the Orthodox Rabbi consulted in accordance with the procedures outlined in paragraph 3 above, it is my desire, and I hereby direct, that no post-mortem procedure be performed on my body.

**7. Incontrovertible Evidence of My Wishes:** If, for any reason, this document is deemed not legally effective as a health care proxy, or if the persons designated in section 1 above as my agent and alternate agent are unable, unwilling or unavailable to serve in such capacity, I declare to my family, my doctor and anyone else whom it may concern that the wishes I have expressed herein with regard to compliance with Jewish law and custom should be treated as incontrovertible evidence of my intent and desire with respect to all health care measures and post-mortem procedures; and that it is my wish that the procedure outlined in section 3 above should be followed in determining the requirements of Jewish law and custom.

**8. Duration and Revocation:** It is my understanding and intention that unless I revoke this proxy and directive, it will remain in effect indefinitely. My signature on this document shall be deemed to constitute a revocation of any prior health care proxy, directive or other similar document I may have executed prior to today's date.

*My Signature* Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: Day: \_\_\_\_\_

Evening: \_\_\_\_\_

### DECLARATION OF WITNESSES

We, on this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_, declare that this document was signed in our presence by the above-named principal, who appeared to be eighteen years of age or older, of sound mind and able to understand the nature and consequences of health care decisions at the time the document was signed. Neither of us is the person appointed as agent (or alternate agent) by this document.

*Witnesses* WITNESS 1:

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Residing at: \_\_\_\_\_

WITNESS 2:

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Residing at: \_\_\_\_\_

### Emergency Instructions

I \_\_\_\_\_, have executed a "Halachic Medical Directive" with respect to medical and post-mortem decisions, dated \_\_\_\_\_. Pursuant to the "Halachic Medical Directive" the persons listed on the reverse of this card are to serve as my agent and alternate agent, respectively, in making health care decisions for me if I become unable to do so on my own. I desire that all such health care decisions, as well as all decisions relating to the handling and disposition of my body after I die, should be made pursuant to Jewish law and custom as determined in accordance with strict Orthodox interpretation and tradition. If there is any questions regarding Jewish law and custom, my agent (or any other person making decisions for me) should consult with and follow the guidance of the rabbi identified on the reverse of this card, or as a second choice the rabbi referred by the institution/organization identified on the reverse of this card, or as a third choice an Orthodox Rabbi whose guidance my health care decision maker in good faith believes I would respect and follow. Pending contact with my agent and/or rabbi, I desire that health care providers should undertake all essential emergency measures on my behalf; and I desire that no autopsy, organ removal, or other post mortem procedure be performed on my body without authorization from my agent and/or rabbi.

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Fold on the dotted line to create a double sided card

### EMERGENCY INSTRUCTIONS

Agent: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Evening: \_\_\_\_\_ Cell: \_\_\_\_\_  
Alternate Agent: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Evening: \_\_\_\_\_ Cell: \_\_\_\_\_  
Rabbi: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Evening: \_\_\_\_\_ Cell: \_\_\_\_\_  
Organization \_\_\_\_\_ Phone: \_\_\_\_\_