The Halachic Medical Directive

DURABLE POWER OF ATTORNEY/DECLARATION WITH RESPECT TO HEALTH CARE DECISIONS AND POST-MORTEM DECISIONS

FOR USE IN MARYLAND

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 May, 2021. 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.

INSTRUCTIONS

(a) Please print your name and address on the first line of the form.

(b) In section 1, print the name, address, and telephone numbers of the person you wish to designate as your 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 primary 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 agents of such arrangements.

Note: This form is effective only if you and your agent(s) are competent adults (an adult is a person 18 years of age or older). An owner, operator, or employee of a health care facility from which you are receiving health care may not serve as a health care agent unless the person is your relative or close friend.

(c) 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 Chayim Aruchim as the organization you select, phone number 718-278-2446.

(d) You can choose whether your agent's authority becomes effective when your primary physician determines that you are unable to make an informed decision regarding your health care or when you signed this document by marking either choice in section 4.

(e) At the conclusion of the form, print the date, sign your name, and print your address.

(f) Two witnesses should sign their names and insert their addresses beneath your signature. These witnesses must be competent adults. **Neither of them should be** the person you have appointed as your health care agent (or alternate agent); and at least one of the witnesses must be an individual who is not knowingly entitled to any portion of your estate or knowingly entitled to any financial benefit by reason of your death.

(g) 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 health care 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 doctor, your lawyer**, and anyone else who is likely to be contacted in times of emergency.

(h) 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.

(i) If at any time you wish to revoke this Halachic Medical Directive, you may do so by destroying or defacing the document or by signing and dating a written statement which expresses your intent to revoke it. To avoid possible confusion, it would be wise to try to obtain all originals and copies of the old Halachic Medical Directive and destroy them.

If you do not revoke this Halachic Medical Directive, it will remain in effect indefinitely. Obviously, if any of the persons whose names you have inserted in the Halachic Medical Directive dies or becomes otherwise incapable of serving in the role you have assigned, it would be wise to execute a new form.

(j) 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.

(k) If, upon consultation with your Rabbi, you would like to add to this Halachic Medical 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.

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ADVANCE DIRECTIVE
APPOINTMENT OF HEALTH CARE AGENT

FOR USE IN MARYLAND

(1) I, _____, residing at _____

_____

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

Agent

Name of Agent:
_____

Address:
_____

Telephone: Day: _____ Telephone: Evening: _____

Cell: _____ Email: _____

Optional: If this agent is unavailable or is unable or unwilling to act as my agent, then I appoint the following person to act in this capacity:

Alternate Agent

Name of Alternate Agent:
_____

Address:
_____

_____

Telephone: Day: _____ Telephone: Evening: _____

Cell: _____ Email: _____

(2) My agent has full power and authority to make health care decisions for me, including the power to:

a. Request, receive, and review any information, oral or written, regarding my physical or mental health, including, but not limited to, medical and hospital records, and consent to disclosure of this information;

b. Employ and discharge my health care providers;

c. Authorize my admission to or discharge from (including transfer to another facility) any hospital, hospice, nursing home, adult home, or other medical care facility; and

d. Consent to the provision, withholding, or withdrawal of health care, including, in appropriate circumstances, life-sustaining procedures.

(3) The authority of my agent is subject to the following provisions and limitations:

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.

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: _____ Telephone: Evening: _____

Cell: _____ Email: _____

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: _____ Email: _____

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: _____ Telephone: 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.

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 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 the above section headed "Ascertaining the Requirements of Jewish Law" 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.

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.

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 the section above headed "Ascertaining the Requirements of Jewish Law", it is my desire, and I hereby direct, that no post-mortem procedure be performed on my body.

(4) My agent's authority becomes operative (initial the option that applies):

____ When my attending physician and a second physician determine that I am incapable of making an informed decision regarding my health care; or

____ When this document is signed.

(5) My agent shall not be liable for the costs of care based solely on this authorization.

By signing below, I indicate that I am emotionally and mentally competent to make this appointment of a health care agent and that I understand its purpose and effect.

My Signature

Signature:

_____

(If you are not physically capable of signing, please ask another person to sign your name on your behalf.)

Print Name:

_____

Date:

_____

Address:

_____

The declarant signed or acknowledged signing this appointment of a health care agent in my presence and based upon my personal observation appears to be a competent individual.

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.

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: _____