ADVANCE HEALTH CARE DIRECTIVE

(California Probate Code Section 4701)

EXPLANATION

You have the right to give instructions about your own health care. You also have the right to name someone else to make health care decisions for you. This form lets you do either or both things. It also lets you express your wishes regarding donation of organs and the designation of your primary physician. If you use this form, you may complete or modify all or any part of it. You are free to use a different form.

Part 1 of this form is a power of attorney for health care. Part 1 lets you name another individual as an agent to make health care decisions for you if you become incapable of making your own decisions or if you want someone else to make those decisions for you now even though you are still capable. You may also name an alternate agent to act for you if your first choice is not willing, able, or reasonably available to make decisions for you. (Your agent may not be an operator or employee of a community care facility or a residential care facility where you are receiving care, or your supervising health care provider or employee of the health care institution where you are receiving care unless your agent is related to you or is a coworker.

Unless the form you sign limits the authority of your agent, your agent may make all health care decisions for you. This form has a place for you to limit the authority of your agent. You need not limit the authority of your agent if you wish to rely on your agent for all health care decisions that may have to be made. If you choose not to limit the authority of your agent, your agent will have the right to:

(a) Consent or refuse to consent to any care, treatment, service, or procedure to maintain, diagnose or otherwise affect a physical or mental condition.
(b) Select or discharge health care providers and institutions.
(c) Approve or disapprove diagnostic tests, surgical procedures, and programs of medication.
(d) Direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care, including cardiopulmonary resuscitation.
(e) Make anatomical gifts, authorize an autopsy, and direct disposition of remains.

Part 2 of this form lets you give specific instructions about any aspect of your health care, whether or not you appoint an agent. Choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive, as well as the provision of pain relief. Space is also provided for you to add to the choices you have made or for you to write out any additional wishes. If you are satisfied to allow your agent to determine what is best for you in making end-of-life decisions, you need not fill out Part 2 of this form.

Part 3 of this form lets you express an intention to donate your bodily organs and tissues following your death.

Part 4 of this form lets you give the authority to your agent to authorize the autopsy and disposition of your remains.

Part 5 of this form lets you give the authority to your agent to sign forms under HIPAA that refer to the release of your medical records.

Part 6 of this form lets you designate a physician to have primary responsibility for your health care. After completing this form, sign and date the form at the end. The form must be signed by two qualified witnesses or acknowledged before a notary public. Give a copy of the signed and completed form to your physician, to any

other health care provider you may have, to any health care institution at which you are receiving care, and to any health care agents you have named. You should talk to the person you have named as an agent to make sure that he or she understands your wishes and is willing to take responsibility.

You have the right to revoke this advanced health care directive or replace this form at any time.

PART 1
POWER OF ATTORNEY FOR HEALTH CARE

1. DESIGNATION OF AGENT. I, DIANA LORRAINE SOUZA, residing at 986 WHITE OAK DRIVE, WILLIAMS, CALIFORNIA 95987, do hereby designate the following individual as my agent to make health care decisions for me:

Agent:
Name: MICHAEL J. SOUZA SR.
Address: 986 WHITE OAK DRIVE
WILLIAMS, CALIFORNIA 95987
Phone: Cell: (530) 312-0586 Work: (530) 406-7700

If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health care decision for me, I designate as my first alternate agent:

First Alternate:
Name: MELINDA D. BUSH
Address: 1301 SPRUCE DRIVE
WOODLAND, CALIFORNIA 95695
Phone: Home: (530) 402-1818 Cell: (530) 379-8128

If I revoke the authority of my agent and first alternate agent or if neither is willing, able, or reasonably available to make a health care decision for me, I designate as my second alternate agent:

Second Alternate:
Name: MICHAEL J. SOUZA JR.
Address: 216 HACIENDA LANE
WOOLDAND, CALIFORNIA 95695
Phone: Cell: (530) 312-2982

2. AGENT'S AUTHORITY. My agent is authorized to make all health care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care to keep me alive.

3. 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 healthcare decisions.

4. AGENT'S OBLIGATION. My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make healthcare decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interests, my agent shall consider my values to the extent known to my agent.

5. NOMINATION OF GUARDIAN OR CONSERVATOR. If a guardian or conservator of my person or estate or both needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able, or reasonably available to act as guardian or conservator, I nominate the alternate agents whom I have named, in the order designated.

PART 2
INSTRUCTIONS FOR HEALTHCARE

If you are satisfied to allow your agent to determine what is best for you in making end-of-life decisions, you need not fill out this part of the form.

6. END-OF-LIFE DECISIONS. 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 initialed below:

RB CHOICE NOT TO PROLONG LIFE. I do not want my life to be prolonged if:

a. I have an incurable and irreversible condition that will result in my death within a relatively short time.

b. I become unconscious, and, to a reasonable degree of medical certainty, I will not regain consciousness.

c. The likely risks and burdens of treatment would outweigh the expected benefits.

7. ARTIFICIAL NUTRITION AND HYDRATION. Artificial nutrition and hydration must be provided, withheld, or withdrawn in accordance with the choice I have made in paragraph 6.

8. RELIEF FROM PAIN. Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death: I DO NOT WANT ADMINISTRATION OF PAIN/ANXIETY MEDICATION FOR THE SOLE PURPOSE OF HASTENING MY DEATH UNLESS DOING SO WILL RELIEVE THE BURDEN OF MY CARE FOR MY FAMILY.

PART 3
DONATION OF ORGANS AT DEATH

9. Upon my death, I wish to donate my organs for purposes of:

RB Transplant

a. Only internal organs may be harvested- heart, heart valves, lungs, liver, kidneys, pancreas, and intestines.

PART 4
AUTOPSY AND DISPOSITION OF REMAINS

10. Upon my death, I give the authority to my agent to authorize an autopsy and make determinations for the disposition of my remains.

PART 5
AUTHORIZATION TO SIGN FORMS UNDER HIPAA

11. With this document I authorize my agent to sign all forms required under HIPAA that refer to but are not limited to the release of my medical records.

PART 6
PRIMARY PHYSICIAN

12. I designate the following as my primary physicians:

Primary Care Physician:
Name: DR. YEE LO
Address: 2081 BRONZE STAR DRIVE
WOODLAND, CALIFORNIA 95776

Primary Cardiologist:
Name: DR. KATHRYN GLATTER
Address: 632 GIBSON ROAD
WOODLAND, CALIFORNIA 95695
Phone: (530) 668-2600

Advanced Heart Failure Cardiologist:
Name: DR. MUNIR JANMOHAMED
Address: 3810 J STREET
SACRAMENTO, CALIFORNIA 958169
Phone: (916) 733-6244

Transplant Physician:
Name: DR. RICHARD CHENG
Address: 400 PARNASSUS AVENUE FIFTH FLOOR
SAN FRANCISCO, CALIFORNIA 94143
Phone: (415) 502-4243

If any of the physicians I have designated above are not willing, able, or reasonably available to act as my physician, I request the nearest available physician be designated as my primary care physician.

PART 7

13. EFFECT OF COPY. A copy of this form has the same effect as the original.

14. SIGNATURE.

Declarant Signature: 

Name: DIANA LORRAINE SOUZA
Address: 986 WHITE OAK DRIVE
WILLIAMS, CALIFORNIA 95987

Date: Feb 15, 2024

15. STATEMENT OF WITNESSES: [If you are a resident in a skilled nursing facility, a patient advocate or ombudsman must sign this statement as one of your two witnesses.]

I declare under penalty of perjury under the laws of California:

(1) that the individual who signed or acknowledged this advance health care directive is personally known to me, or that the individual's identity was proven to me by convincing evidence,
(2) that the individual signed or acknowledged this advance directive in my presence,
(3) that the individual appears to be of sound mind and under no duress, fraud, or undue influence,
(4) that I am not a person appointed as agent by this advance directive,
(5) that I am not the individual's health care provider, an employee of the individual's health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility for the elderly, nor an employee of an operator of a residential care facility for the elderly, and
(6) that I am an adult.

Witness Signature: 

Name: DAVID STOERMER
Address: 1301 SPRUCE DRIVE
WOODLAND, CALIFORNIA 95695

Date: 2-15-24

Witness Signature: 

Name: SYDNEY GASTINEAU
Address: 706 GIBSON ROAD
WOODLAND, CALIFORNIA 95695

Date: 2/15/24

16. ADDITIONAL STATEMENT OF WITNESSES. At least one of the above witnesses must also sign the following declaration.

I further declare under penalty of perjury under the laws of California that I am not related to the individual executing this advance health care directive by blood, marriage, or adoption, and to the best of my knowledge, I am not entitled to any part of the individual's estate upon his or her death under a will now existing or by operation of law.

Witness Signature: _____

Name: SYDNEY GASTINEAU
Address: 706 GIBSON ROAD
WOODLAND, CALIFORNIA 95695

Date: 2/15/24