

**ADVANCE HEALTH CARE DIRECTIVE AMENDMENT AND SUPPLEMENT:  
POWER OF MY AGENT TO AUTHORIZE CARE OVER MY OBJECTION**

I, \_\_\_\_\_, hereby amend my Advance Directive for Health Care, dated \_\_\_\_\_, which is hereby ratified, incorporated in and made a part of this document, to add the following terms. If there is any conflict between the terms below and the Advance Directive that they amend, the terms below shall control:

**Special Powers of My Agent to Authorize Health Care Over My Objection**

*[This allows you to authorize your healthcare agent to consent to treatment recommended by your physician even if you are objecting at that time because of the effects of mental disorder. If you want to give your agent this authority, you should check and initial the boxes next to the special powers you want to give your agent.]*

If I am incapable of making informed decisions about my health care and I am objecting to health care that my agent and my physician believe I need, my agent shall have the following power(s):

- \_\_\_\_\_ 1. To authorize my admission to a health care facility for the treatment of mental illness as permitted by law, even if I object.
- \_\_\_\_\_ 2. To authorize other health care that is permitted by law, that is consistent with my other instructions in my Advance Directive, and that my health care agent and my physician believe I need, even if I object. This would include all health care with the exception of the types of health care I have written in the space below:

I do **not** authorize my agent to authorize the following specific types of health care over my objection:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*[These instructions will not be legally binding unless a qualified licensee identified below certifies, in the space provided below, that you understand the consequences of giving your agent these powers.]*

I am licensed in Virginia as an attending physician, a clinical psychologist, a physician assistant, a nurse practitioner, a professional counselor, or a clinical social worker familiar with the person who has made this Amendment and Supplement to this person's advance directive for health care. I attest that this person: (1) is presently capable of making an informed decision and (2) understands the consequences of the special powers given to this person's agent by this Amendment and Supplement.	
_____ Licensee Signature	_____ Date
_____ Printed Name and Address of Licensee	

\_\_\_\_\_  
Signature of Declarant

\_\_\_\_\_  
Date

The declarant signed the foregoing amendment to his/her advance directive in my presence.  
[TWO ADULT WITNESSES NEEDED]

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Witness Printed

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Witness Printed

**NOTE: YOU NEED TO PHYSICALLY ATTACH THIS DOCUMENT (OR A COPY) TO YOUR ADVANCE DIRECTIVE AND TO ALL COPIES OF YOUR ADVANCE DIRECTIVE THAT YOU GIVE (OR HAVE GIVEN) TO OTHERS.**

**ADVANCE HEALTH CARE DIRECTIVE AMENDMENT AND SUPPLEMENT:  
POWER OF MY AGENT TO AUTHORIZE CARE OVER MY OBJECTION WITH  
INCORPORATION OF VIRGINIA CODE § 64.2-104 MEMORANDUM**

I, \_\_\_\_\_, hereby amend my Advance Directive for Health Care, dated \_\_\_\_\_, which is hereby ratified, incorporated in and made a part of this document, to add the following terms. I have completed or may hereafter complete a letter or memorandum of my views or directives in the exercise of the powers conferred in this instrument pursuant to Virginia Code § 64.2-104. If there is any conflict between the terms below and the Advance Directive that they amend, the terms below shall control:

**Special Powers of My Agent to Authorize Health Care Over My Objection**

*[This allows you to authorize your healthcare agent to consent to treatment recommended by your physician even if you are objecting at that time because of the effects of mental disorder. If you want to give your agent this authority, you should check and initial the boxes next to the special powers you want to give your agent.]*

If I am incapable of making informed decisions about my health care and I am objecting to health care that my agent and my physician believe I need, my agent shall have the following power(s):

- \_\_\_\_\_ 1. To authorize my admission to a health care facility for the treatment of mental illness as permitted by law, even if I object.
- \_\_\_\_\_ 2. To authorize other health care that is permitted by law, that is consistent with my other instructions in my Advance Directive, and that my health care agent and my physician believe I need, even if I object. This would include all health care with the exception of the types of health care I have written in the space below:

I do **not** authorize my agent to authorize the following specific types of health care over my objection:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*[These instructions will not be legally binding unless a licensee identified below certifies, in the space provided below, that you understand the consequences of giving your agent these powers.]*

<p>I am licensed in Virginia as an attending physician, a clinical psychologist, a physician assistant, a nurse practitioner, a professional counselor, or a clinical social worker familiar with the person who has made this Amendment and Supplement to this person's advance directive for health care. I attest that this person: (1) is presently capable of making an informed decision and (2) understands the consequences of the special powers given to this person's agent by this Amendment and Supplement.</p>	
_____ Licensee Signature	_____ Date
_____ Printed Name and Address	

\_\_\_\_\_  
Signature of Declarant

\_\_\_\_\_  
Date

The declarant signed the foregoing amendment to his/her advance directive in my presence (2 witnesses required).

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Witness Printed

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Witness Printed

**NOTE: YOU NEED TO PHYSICALLY ATTACH THIS DOCUMENT (OR A COPY) TO YOUR ADVANCE DIRECTIVE AND TO ALL COPIES OF YOUR ADVANCE DIRECTIVE THAT YOU GIVE (OR HAVE GIVEN) TO OTHERS.**