Minnesota Health Care Directive[1]
Short Form[2]

Name _____ Date of Birth: _____

My Health Care Agent

If I can't make my own medical decisions, I want this person to speak for me. I understand my Health Care Agent cannot be my doctor, nurse, or anyone who provides my direct medical care unless they are a family member.

Primary Health Care Agent

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

Alternate Health Care Agent (optional)

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

My Health Care Instructions (optional)

Write down what matters most to you about your health care. You can include what's important to you, the treatments you do or do not want, where you would like to receive care (at home, in a hospital, or in a nursing home), and if you want to be an organ, tissue, or eye donor.

1 A long form is available if you wish to more fully describe your health care wishes.
2 This document doesn't cover certain mental health treatments, like shock therapy or strong mood-stabilizing medications.

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Legal Authority

This form must be signed in front of two witnesses or a notary public. The witnesses or the notary cannot be the named Health Care Agent.

Signature: _____ **Date:** _____

Option 1 – Notary Public

In the State of Minnesota, County of _____ , on _____(date)

_____(name) acknowledged their signature on this form.

Notary Stamp

Notary Signature: _____

Notary Commission Expires: _____

Option 2 – Two Witnesses

Witnesses are 18 years of age or older and are not my primary or alternate health care agent. Only one may be a health care provider or employee giving direct care to me.

Witness 1

Name: _____

Signature: _____

Date: _____

Are you a health care provider or an employee of a provider giving direct care to this person?

☐ Yes ☐ No

Witness 2

Name: _____

Signature: _____

Date: _____

Are you a health care provider or an employee of a provider giving direct care to this person?

☐ Yes ☐ No