

**ADVANCE DIRECTIVE
(STATE OF OREGON)**

This form may be used in Oregon to choose a person to make health care decisions for you if you become too sick to speak for yourself. The person is called a Health Care Representative. If you do not have an effective Health Care Representative appointment and become too sick to speak for yourself, a Health Care Representative will be appointed for you in the order of priority set forth in ORS 127.635 (2).

This form also allows you to express your values and beliefs with respect to health care decisions and your preferences for health care.

- If you have completed an Advance Directive in the past, this new Advance Directive will replace any older directive.
- You must sign this form for it to be effective. You must also have it witnessed by two witnesses or a notary. Your appointment of a Health Care Representative is not effective until the Health Care Representative accepts the appointment.
- If your Advance Directive includes directions regarding the withdrawal of life support or tube feeding, you may revoke your Advance Directive at any time and in any manner that expresses your desire to revoke it.
- In all other cases, you may revoke your Advance Directive at any time and in any manner as long as you are capable of making medical decisions.

1. ABOUT ME

Name: Pamela G. Escobar Date of Birth: January 29, 1941

Phone: (541) 505-7439

Address: 1514 Diamond Street, Springfield, Oregon 97477

2. MY HEALTH CARE REPRESENTATIVE

I choose the following persons as my Health Care Representatives to make health care decisions for me if I can't speak for myself.

Name: Antone (Tony) R. Escobar and Joseph G. Escobar Relationship: Spouse and Son

Phone (Pamela): (541) 505-7439

Address (Pamela): 1514 Diamond Street, Springfield, Oregon 97477

Phone (Joseph): (541) 510-3760

Address (Joseph): 838 Diamond Street, Springfield, Oregon 97477

I choose the following people to be my alternate Health Care Representatives if my first choice is not available to make health care decisions for me or if I cancel the first Health Care Representative's appointment.

First Alternate Health Care Representative:

Name: Andrew D. Escobar Relationship: Son

Phone: 650-996-5202

Address: _____

Second Alternate Health Care Representative:

Name: Patsy F. Escobar Relationship: Daughter in Law

Phone: 541-736-9600

Address: 838 Diamond Street, Springfield, Oregon 97477

3. INSTRUCTIONS TO MY HEALTH CARE REPRESENTATIVE

If you wish to give instructions to your Health Care Representative about your health care decisions, initial one of the following three statements:

____ To the extent appropriate, my Health Care Representative must follow my instructions.

____ My instructions are guidelines for my Health Care Representative to consider when making decisions about my care.

____ Other instructions: _____

4. DIRECTIONS REGARDING MY END OF LIFE CARE

In filling out these directions, keep the following in mind:

- The term “as my health care provider recommends” means that you want your health care provider to use life support if your health care provider believes it could be helpful, and that you want your health care provider to discontinue life support if your health care provider believes it is not helping your health condition or symptoms.
- The term “life support” means any medical treatment that maintains life by sustaining, restoring, or replacing a vital function.
- The term “tube feeding” means artificially administered food and water.
- If you refuse tube feeding, you should understand that malnutrition, dehydration, and death will probably result.
- You will receive care for your comfort and cleanliness no matter what your choices.

A. Statement Regarding End of Life Care.

You may initial the statement below if you agree with it. If you initial the statement you may, but you do not have to, list one or more conditions for which you do not want to receive life support.

_____ I do not want my life to be prolonged by life support. I also do not want tube feeding as life support. I want my health care provider to allow me to die naturally if my health care provider and another knowledgeable health care provider confirm that I am in any of the medical conditions listed below.

B. Additional Directions Regarding End of Life Care.

Here are my desires about my health care if my health care provider and another knowledgeable health care provider confirm that I am in a medical condition described below:

i. Close to Death.

If I am close to death and life support would only postpone the moment of my death:

INITIAL ONE:

- _____ I want to receive tube feeding.
 _____ I want tube feeding only as my health care provider recommends.
 _____ I DO NOT WANT tube feeding.

INITIAL ONE:

- _____ I want any other life support that may apply.
 _____ I want life support only as my health care provider recommends.
 _____ I DO NOT WANT life support.

ii. Permanently Unconscious.

If I am unconscious and it is very unlikely that I will ever become conscious again:

INITIAL ONE:

- ☐ I want to receive tube feeding.
- ☐ I want tube feeding only as my health care provider recommends.
- ☐ I DO NOT WANT tube feeding.

INITIAL ONE:

- ☐ I want any other life support that may apply.
- ☐ I want life support only as my health care provider recommends.
- ☐ I DO NOT WANT life support.

iii. Advanced Progressive Illness.

If I have a progressive illness that will be fatal and is in an advanced stage, and I am consistently and permanently unable to communicate by any means, swallow food and water safely, care for myself and recognize my family and other people, and it is very unlikely that my condition will substantially improve:

INITIAL ONE:

- ☐ I want to receive tube feeding.
- ☐ I want tube feeding only as my health care provider recommends.
- ☐ I DO NOT WANT tube feeding.

INITIAL ONE:

- ☐ I want any other life support that may apply.
- ☐ I want life support only as my health care provider recommends.
- ☐ I DO NOT WANT life support.

iv. Extraordinary Suffering.

If life support would not help my medical condition and would make me suffer permanent and severe pain:

INITIAL ONE:

- ☐ I want to receive tube feeding.
- ☐ I want tube feeding only as my health care provider recommends.
- ☐ I DO NOT WANT tube feeding.

INITIAL ONE:

- ☐ I want any other life support that may apply.
- ☐ I want life support only as my health care provider recommends.
- ☐ I DO NOT WANT life support.

C. Additional Instructions.

You may attach to this document any writing or recording of your values and beliefs related to health care decisions. These attachments will serve as guidelines for health care providers. Attachments may include a description of what you would like to happen if you are close to death, if you are permanently unconscious, if you have an advanced progressive illness or if you are suffering permanent and severe pain.

5. MY SIGNATURE

Signature: _____ Date: _____

6. NOTARY OR WITNESS

Complete either A. or B. when you sign.

A. Notary

STATE OF OREGON)
) ss.
COUNTY OF LANE)

Signed or attested before me on _____.

Notary Public for Oregon
My Commission Expires: _____

B. Witness Declaration.

The person completing this form is personally known to me or has provided proof of identity, has signed or acknowledged the person's signature on the document in my presence and appears to be not under duress and to understand the purpose and effect of this form. In addition, I am not the person's Health Care Representative or alternate Health Care Representative, and I am not the person's attending health care provider.

Witness Name (print): _____

Signature: _____

Date: _____

Witness Name (print): _____

Signature: _____

Date: _____

7. **ACCEPTANCE BY MY HEALTH CARE REPRESENTATIVE**

I accept this appointment and agree to serve as Health Care Representative.

Health Care Representatives:

Printed Name: _____

Signature: _____

Date: _____

Printed Name: _____

Signature: _____

Date: _____

First Alternate Health Care Representative:

Printed Name: _____

Signature: _____

Date: _____

Second Alternate Health Care Representative:

Printed Name: _____

Signature: _____

Date: _____

**ADVANCE DIRECTIVE – ADDITIONAL INSTRUCTIONS
(STATE OF OREGON)**

Initial next to the instructions you want followed:

- _____ **Authority of Health Care Representative.** I am appointing a Health Care Representative to make all medical and placement decisions for me and to protect my interests without the necessity of a court appointed guardian. My representative shall have all powers granted to a Health Care Representative under Oregon Revised Statutes, Chapter 127, as amended, and, in addition, under all circumstances, shall have the same authority over my physical and mental health care as I would have if capable, regardless of whether such powers are inherently vested in law. My representative's authority includes but is not limited to: the right to receive and review medical records, to consent to disclosure of such records, to consent to or withhold medical treatment, to consent to or direct my admission to or retention in a health care facility for care or treatment, and to consent or withhold life support, consistent with the instructions in this Advance Directive.
- _____ **Disposition of Remains.** It is my intent that any authorization concerning disposition of my remains in this Advance Directive act as and be accepted as the written authorization presently required by ORS 97.130 (or its corresponding future provisions) or any other provision of Oregon Law, authorizing me to name a person to have authority to dispose of my remains.
- _____ **Individual Worksheet.** I hereby attach and incorporate into this Advance Directive the completed Individual Worksheet found at the back of these Additional Instructions.
- _____ **No Treatment Which Merely Prolongs Inevitable Death.** I recognize that modern medical technology has made possible the artificial prolongation of my life beyond natural limits. I do not wish to artificially prolong the process of my dying if continued health care will not improve my prognosis for recovery or otherwise enable me to live a productive and/or enjoyable life and my death is likely to occur within several months, or if I require life support as the result of an irreversible condition, even if that life support might prolong my life for a sustained period. Therefore, I do not want efforts made to prolong my life and I do not want life-sustaining treatment to be provided or continued (1) if I am in an irreversible coma or persistent vegetative state; or (2) if I am terminally ill and the use of life-sustaining procedures would serve only to artificially delay the moment of my death; or (3) under any other circumstances in which the burdens of the treatment outweigh the expected benefits. By "an irreversible coma," I mean a coma from which the treating physicians have reasonably concluded I will never regain consciousness. In making decisions about life-sustaining treatment under provision (3) above, I want my agent to consider the relief of suffering and quality of remaining life as well as the extent of the possible prolongation of my life.
- _____ **Treat Unless in Irreversible Coma.** I want to receive medical treatment that prolongs and sustains my life unless I am in an irreversible coma. By an "irreversible coma" I mean a coma from which the treating physician or physicians have reasonably concluded I will

never regain consciousness. If I am in such an irreversible coma, I do not want to receive medical treatment that prolongs and sustains my life. At the same time that I am signing this advance health care directive, I am entering my initials in the space immediately below this provision to show that I have read this provision and that it reflects my desires.

_____ **No Life-Sustaining Procedures if in Terminal Condition.** If I am in a terminal condition, I do not want any life-sustaining procedures to be used to prolong my life. For purposes of this document, (1) “terminal condition” shall mean an incurable condition caused by injury, disease, or illness, which, regardless of the application of life-sustaining procedures, would, within reasonable medical judgment, produce death and in which the application of life-sustaining procedures serves only to postpone the moment of my death; and (2) “life-sustaining procedures” shall mean any medical procedure or intervention that utilizes mechanical or other artificial means to sustain, restore, or supplant a vital function which will serve only to artificially prolong the moment of my death. The term “life-sustaining procedures” shall not include the administration of medication or the performance of any medical procedure deemed necessary to alleviate pain. At the same time that I am signing this advance health care directive, I am entering my initials in the space immediately below this provision to show that I have read this provision and that it reflects my desires.

_____ **Treat to Allow Life as Long as Possible.** I want to live as long as possible; therefore, I want to receive all medical treatment that will prolong and sustain my life within the limits of generally accepted health care standards. I want such treatment provided to me regardless of my chances of recovery, my condition, or the cost of such treatment. At the same time that I am signing this advance health care directive, I am entering my initials in the space immediately below this provision to show that I have read this provision and that it reflects my desires.

_____ **Hiring and Discharge of Doctors.** I authorize my Health Care Representative to hire and discharge doctors and other health care personnel on my behalf.

_____ **Medical Records.** Effective immediately, my Health Care Representative shall be considered my “personal representative” as that term is used in the federal Health Insurance Portability and Accountability Act (“HIPAA”). My Health Care Representative may review my medical records and may authorize their release to those persons whom my Health Care Representative designates. I authorize my physicians and other health care professionals to discuss my medical condition with my Health Care Representative and those designated by my Health Care Representative.

_____ **Hospice Care.** My Health Care Representative may authorize and arrange for hospice care on my behalf.

_____ **Pain Control.** If I am terminally ill or otherwise close to death, I desire to be kept pain-free, even if pain medication might make me less responsive or impair my respiration or other bodily functions. I want sufficient pain medications, and anti-anxiety medications, if necessary, to ensure my comfort even if the administration of such medications may hasten

the moment of my death and I direct my Health Care Representative to authorize and monitor the administration of such medications.

_____ **End of Life.** I wish to die at home and not in a hospital or other care facility. If I am in the final stages of life, I wish to be transferred to my home even if there is a risk that the transfer itself may accelerate my time of death.

_____ **Dementia and Quality of Life.** If I have been diagnosed with advanced dementia requiring 24-hour care, I want no life-prolonging measures, including antibiotics.

_____ **Spoon Feeding.** The quality of my life is of supreme importance to me, even at the end. When the time comes, I do not want any extraordinary measures taken to extend my life. This includes any spoon feeding by staff if I am at a stage of dementia or failing health in which the offering of food by spoon to the mouth elicits an automatic response to take in the food. Should this be a conflict at the facility, I direct my Health Care Representative to move me back home or to a homelike setting and have either family or a trusted friend be with me. I do not wish to be kept alive because I am having an automatic memory response to a utensil with food placed on my lips.

_____ **Remain at Home.** I would prefer to stay in my home as long as possible. But I leave all long-term care placement decisions, including whether or not I can remain in my home, to my Health Care Representative. At any time that I am incapable of giving or withholding informed consent for medical care, including mental health and dementia care, my Health Care Representative shall have the express authority to authorize or withhold any and all medical and psychiatric care, including psychoactive medications, and authorize my admission to, or retention in, a facility, hospital, or specialized dementia care unit for care or treatment.

_____ **Temporary Life Support Measures.** I am not opposed to temporary life support measures, for a short period of time for diagnostic purposes, or where my chances of recovery are well identified, and based strictly on quality of life. I do not wish to be subjected to the indignities of deterioration, dependence, and hopeless pain. Therefore, if the situation should arise which has not been covered herein, in which there is no reasonable expectation of my recovery, I request that I be allowed to die and not be kept alive by artificial means or "heroic measures."

_____ **Cremation.** I wish to be cremated, not buried and my remains returned to my representative for final disposition.

_____ **Funeral or Memorial Service.** I do not want a funeral or other formal memorial service held in my memory. I request instead that my family and close friends gather for a meal and remind each other of great times we have had. I authorize my Health Care Representative to make and/or carry out any necessary funeral arrangements consistent with these instructions.

Signature: _____

Date: _____

Authorization for Release of Protected Health Information of PAMELA G. ESCOBAR

(Valid Authorization Under 45 CFR Chapter 164 and ORS 192.518 to 192.524 – Protected Health Information)

Statement of Intent: It is my understanding that Congress passed a law entitled the Health Insurance Portability and Accountability Act (“HIPAA”) that limits use, disclosure or release of my individually identifiable health information (or, sometimes herein, “protected medical information”). This Authorization is being signed because it is crucial that my health care providers readily use, release or disclose my protected medical information to, or as directed by, that person or those persons designated in this Authorization in order to allow me the advantage of being able to discuss with, and obtain advice from, others or to facilitate decisions regarding my health care when I otherwise may not be able to discuss these matters with health care providers without regard to whether any health care provider has certified in writing that I am incompetent” for purposes of Oregon Revised Statutes Chapter 127.

1. Appointment of Authorized Recipients:

I, PAMELA G. ESCOBAR, an individual, hereby appoint the following persons, or any of them, as Authorized Recipients for health care disclosure under the Standards for Privacy of Individually Identifiable Health Care Information (45 CFR Parts 160 and 164) under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and ORS 192.518 to 192.524 – Protected Health Information:

ANTONE R. ESCOBAR, Spouse

JOSEPH G. ESCOBAR, Son

ANDREW D. ESCOBAR, Son

PATSY F. ESCOBAR, Daughter in Law

HANNAH M. ESCOBAR, Granddaughter JOSEPH GLYNN, Brother

2. Grant of Authority:

Therefore, as authorized by 45 CFR Sec(s). 164.502(a)(1)(i) and (iv), 164.502(a)(2)(i), 164.524 and 164.528, a covered entity (being a health care provider as defined by HIPAA) is permitted to use, release and disclose my individually identifiable health information pursuant to and in compliance with this valid Authorization.

I hereby authorize:

- a. All covered persons and entities as defined in HIPAA, including but not limited to a doctor (including but not limited to a physician, podiatrist, chiropractor, or osteopath), psychiatrist, psychologist, dentist therapist, nurse, hospitals, clinics, pharmacy, laboratory, ambulance service, assisted living facility, residential care facility, bed and board facility, nursing home, medical insurance company or any other health care provider or affiliate,

- b. to use, release and disclose the following information at the request of an Authorized Recipient:

Any and all individually identifiable health care information, reports and/or records concerning my medical and psychiatric history, condition, diagnosis, testing, prognosis, treatment, billing information and identity of health care providers, whether past, present or future and any other information which is in any way related to my health care. Additionally, this disclosure shall include the ability to ask questions and discuss this protected medical information with the person or entity who has possession of the protected medical information even if I am fully competent to ask questions and discuss this matter at the time. It is my intention to give a full authorization for access to, disclosure and release of ANY protected medical information by or to the persons named in this Authorization as if each person were me;

- c. to, or as requested by, an Authorized Recipient.

3. Termination:

This Authorization is not affected by, and shall not terminate by reason of, my subsequent disability or incapacity. This Authorization shall terminate on 1 year following my death or upon written revocation expressly referring to this authorization and the date it is actually received by the covered entity. Proof of receipt of my written revocation may be by certified mail, registered mail, facsimile, or any other receipt evidencing actual receipt by the covered entity. Such revocation shall be effective upon the actual receipt of the notice by the covered entity except that the covered entity has taken action in reliance on it.

4. Re-disclosure:

By signing this Authorization, I acknowledge that the information used, disclosed or released pursuant to this Authorization may be subject to re-disclosure by an Authorized Recipient whose names are written in paragraph 1 of this Authorization and the information once disclosed will no longer be protected by the rules created in HIPAA. No covered entity shall require an Authorized Recipient to indemnify the covered entity to comply with this Authorization.

5. Instructions to the Authorized Recipients:

An Authorized Recipient shall have the right to bring a legal action in any applicable forum against any covered entity that refuses to recognize and accept this Authorization for the purposes that I have expressed. Additionally, an Authorized Recipient is authorized to sign any documents that the Authorized Recipient deems appropriate to obtain use, disclosure or release of the protected medical information.

6. Effect of Duplicate Originals or Copies:

If this Authorization has been executed in multiple counterparts, each counterpart original will have equal force and effect. An Authorized Recipient may make photocopies of this Authorization and each photocopy will have the same force and effects as the original.

7. My Waiver and Release:

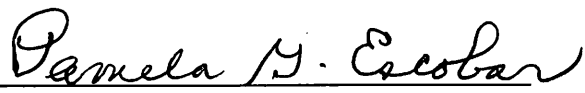
With regard to information disclosed pursuant to this Authorization, I waive any right of privacy that I may have under the authority of the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 (HIPAA), any amendment or successor to that Act, or any similar state or federal act, rule or regulation. In addition, I hereby release any covered entity that acts in reliance on this Authorization from any liability that may accrue from the use or disclosure of my protected medical information in reliance upon this Authorization and for any actions taken by an Authorized Recipient.

8. Severability:

I intend that this Authorization conform to United States and Oregon law. In the event that any provision of this document is invalid, the remaining provisions shall nonetheless remain in full force and effect.

I understand that I have the right to receive a copy of this Authorization. I also understand that I have the right to revoke this Authorization and that any revocation of this Authorization must be in writing.

Dated: MAY 25, 2021

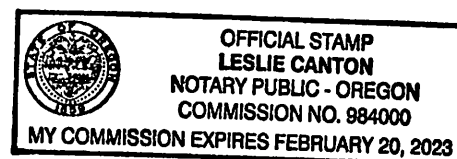

PAMELA G. ESCOBAR, Principal
Date of Birth: January 29, 1941

STATE OF OREGON)
) ss.
COUNTY OF LANE)

This instrument was acknowledged before me on MAY 25, 2021, by PAMELA G. ESCOBAR, as Principal.



LESLIE CANTON
My commission expires: 2/20/2023



APPOINTMENT OF PERSON TO MAKE DECISIONS

CONCERNING DISPOSITION OF REMAINS OF

PAMELA G. ESCOBAR

I, PAMELA G. ESCOBAR, appoint,

_____, whose address and telephone number is _____, as the person to make all decisions regarding the disposition of my remains upon my death for my burial or cremation. In the event he is unable to act, I appoint _____, whose address and telephone number is _____, as my alternate person to make all decisions regarding the disposition of my remains upon my death for my burial or cremation.

I express my preference for: (please initial one selection)

☐ Cremation
☐ Burial
☐ No Preference

It is my intent that this Appointment of Person to Make Decisions Concerning Disposition of Remains act as and be accepted as the written authorization presently required by ORS 97.130 (or its corresponding future provisions) or any other provisions of Oregon Law, authorizing me to name a person to have authority to dispose of my remains.

Dated _____

PAMELA G. ESCOBAR

DECLARATION OF WITNESSES

We declare that PAMELA G. ESCOBAR is personally known to us, that PAMELA G. ESCOBAR signed this Appointment of Person to Make Decisions Concerning Disposition of Remains in our presence, that she appeared to be of sound mind and not acting under duress, fraud or undue influence, and that neither of us is the person so appointed by this document.

Witnessed by:

_____ Residing at _____, Oregon.

_____ Residing at _____, Oregon.