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**MARYLAND LIVING WILL AND ADVANCE MEDICAL DIRECTIVE:  
PLANNING FOR FUTURE HEALTH CARE DECISIONS**

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By: Sherry Lynette Rison  
(Print Name)

Date of Birth: 12/29/54  
(Month/Day/Year)

On 01/29, 2014, I, **SHERRY LYNETTE RISON**, of Newburg, Maryland, being of sound mind, voluntarily direct that my dying shall not be artificially prolonged under the circumstances set forth in this declaration.

**PART I: SELECTION OF HEALTH CARE AGENT**

**A. Selection of Primary Agent**

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

Name of Agent: **WILLIAM EDWARD RISON**  
Agent's Address: P.O. Box 755, Newburg, MD 20664  
Agent's Telephone Number: 301-259-0089

**B. Selection of Back-up Agent**

If my primary agent cannot be contacted in time or for any reason is unavailable or unable or unwilling to act as my agent, then I select the following person to act in this capacity:

Name of Back-up Agent: **SUSAN ROXANNE PATTON**  
Back-up Agent's Address: 14 Deep Run Road, Fredericksburg, VA 22406  
Back-up Agent's Telephone Number: 540-752-2490

**C. Powers and Rights of Health Care Agent**

I want my agent to have full power to make health care decisions for me, including the power to:

1. Consent or not to medical procedures and treatments which my doctors offer, including things that are intended to keep me alive, like ventilators and feeding tubes;
2. Decide who my doctor and other health care providers should be; and
3. Decide where I should be treated, including whether I should be in a hospital, nursing home, other medical care facility, or hospice program.

4. I also want my agent to:

- a. Ride with me in an ambulance if ever I need to be rushed to the hospital; and
- b. Be able to visit me if I am in a hospital or any other health care facility.

THIS ADVANCE DIRECTIVE DOES NOT MAKE MY AGENT  
RESPONSIBLE FOR ANY OF THE COSTS OF MY CARE.

**D. How My Agent Is To Decide Specific Issues**

I trust my agent's judgment. My agent should look first to see if there is anything in Part II of this advance directive that helps decide the issue. Then, my agent should think about the conversations we have had, my religious or other beliefs and values, my personality, and how I handled medical and other important issues in the past. If what I would decide is still unclear, then my agent is to make decisions for me that my agent believes are in my best interest. In doing so, my agent should consider the benefits, burdens, and risks of the choices presented by my doctors.

**E. Access to my Health Information – Federal Privacy Law (HIPAA) Authorization**

- 5. If, prior to the time the person selected as my agent has power to act under this document, my doctor wants to discuss with that person my capacity to make my own health care decisions, I authorize my doctor to disclose protected health information which relates to that issue.
- 6. My agent may 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 other protected health information, and consent to disclosure of this information.
- 7. For all purposes related to this document, my agent is my personal representative under the Health Insurance Portability and Accountability Act (HIPAA). My agent may sign, as my personal representative, any release forms or other HIPAA-related materials.
- 8. All of the rights in Part I, Section E are also vested in my back-up agent at the time this power of attorney becomes effective.

**F. Effectiveness of This Part**

My agent's power is in effect whenever I am not able to make informed decisions about my healthcare, either because the doctor in charge of my care (attending physician) decides that I have lost this ability *temporarily*, or my attending physician and a consulting doctor agree that I have lost this ability *permanently*.

## **PART II: TREATMENT PREFERENCES ("LIVING WILL")**

### **A. Preference in Case of Terminal Condition**

If my doctors certify that my death from a terminal condition is imminent, even if life-sustaining procedures are used, keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means.

### **B. Preference in Case of Persistent Vegetative State**

If my doctors certify that I am in a persistent vegetative state, that is, if I am not conscious and am not aware of myself or my environment or able to interact with others, and there is no reasonable expectation that I will ever regain consciousness, keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means.

### **C. Preference in Case of End-Stage Condition**

If my doctors certify that I am in an end-stage condition, that is, an incurable condition that will continue in its course until death and that has already resulted in loss of capacity and complete physical dependency, keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means.

### **D. Pain Relief**

No matter what my condition, give me the medicine or other treatment I need to relieve pain.

### **E. Effect of Stated Preferences**

I realize I cannot foresee everything that might happen after I can no longer decide for myself. My stated preferences are meant to guide whoever is making decisions on my behalf and my health care providers, but I authorize them to be flexible in applying these statements if they feel that doing so would be in my best interest.

### DECLARANT AND WITNESS SIGNATURES

By signing below as the Declarant, I indicate that I am emotionally and mentally competent to make this advance directive and that I understand its purpose and effect. I also understand that this document replaces any similar advance directive I may have completed before this date.

Sherry Lynette Rison      Oct 29, 2014  
(Signature of Declarant)      (Date)

Under penalty of perjury, we state that this declaration was signed by **SHERRY LYNETTE RISON** in our presence. At her request, in her presence, and in the presence of each other, we have signed our names as witnesses on October 29, 2014. Further, each of us individually states that:

3. The declarant is known to me, and based upon my personal observation, the declarant appears to be emotionally and mentally competent to make this advance directive.
4. Based upon information and belief, I am not related to the declarant by blood or marriage, am not a creditor of the declarant, am not entitled to any portion of the estate of the declarant under any existing testamentary instrument of the declarant, am not entitled to any financial benefit by reason of the death of the declarant, am not financially or otherwise responsible for the declarant's medical care, and am not an employee of any such person or institution.

Alhazary Pardo  
(Witness #1 Signature)

Victoria Chan-Pardo  
(Name Printed)

4000 Mitchellville Rd, #222  
(Address)

Bowie, MD 20716  
(City, State & Zip)

301-805-6080  
(Telephone Number)

Denise A. Martin  
(Witness #2 Signature)

Denise A. Martin  
(Name Printed)

4000 Mitchellville Rd,  
(Address)      Ste. 222

Bowie, MD 20716  
(City, State & Zip)

301-805-6080  
(Telephone Number)

**Prepared by: McChesney & Dale, P.C., 4000 Mitchellville Rd., Ste. 222, Bowie, MD 20716**  
**Phone (301) 805-6080 Fax (301) 805-6086 [www.mchesneydale.com](http://www.mchesneydale.com)**

**Maryland Statutory Living Will and Advance Medical Directive**

This document was prepared by the law firm of McChesney & Dale, P.C., and complies with Md. Health-General Code Ann. § 5-603.