GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2025

H.B. 349 Mar 10, 2025 HOUSE PRINCIPAL CLERK

D

H HOUSE BILL DRH30158-MG-119

Short Title: Update Reqs./Advance Health Care Directives. (Public)

Sponsors: Representative Huneycutt.

Referred to:

A BILL TO BE ENTITLED

AN ACT UPDATING REQUIREMENTS FOR HEALTH CARE POWERS OF ATTORNEY AND ADVANCE HEALTH CARE DIRECTIVES; AND AUTHORIZING THE SECRETARY OF STATE TO RECEIVE ELECTRONIC FILINGS OF ADVANCE HEALTH CARE DIRECTIVES.

The General Assembly of North Carolina enacts:

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PART I. HEALTH CARE POWERS OF ATTORNEY

SECTION 1.1. G.S. 32A-16(3) reads as rewritten:

"(3) Health care power of attorney. – Except as provided in G.S. 32A-16.1, a written instrument that substantially meets the requirements of this Article, that is signed in the presence of two qualified witnesses, and witnesses or acknowledged before a notary public, pursuant to which an attorney-in-fact or agent is appointed to act for the principal in matters relating to the health care of the principal. The notary who takes the acknowledgement may but is not required to be a paid employee of the attending physician or mental health treatment provider, a paid employee of a health facility in which the principal is a patient, or a paid employee of a nursing home or any adult care home in which the principal resides."

SECTION 1.2. G.S. 32A-25.1(a) reads as rewritten:

"(a) The use of the following form in the creation of a health care power of attorney is lawful and, when used, it shall meet the requirements of and be construed in accordance with the provisions of this Article:

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HEALTH CARE POWER OF ATTORNEY

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29 30 NOTE: YOU SHOULD USE THIS DOCUMENT TO NAME A PERSON AS YOUR HEALTH CARE AGENT IF YOU ARE COMFORTABLE GIVING THAT PERSON BROAD AND SWEEPING POWERS TO MAKE HEALTH CARE DECISIONS FOR YOU. THERE IS NO LEGAL REQUIREMENT THAT ANYONE EXECUTE A HEALTH CARE POWER OF ATTORNEY.

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EXPLANATION: You have the right to name someone to make health care decisions for you when you cannot make or communicate those decisions. This form may be used to create a health care power of attorney, and meets the requirements of North Carolina law. However, you are not required to use this form, and North Carolina law allows the use of other forms that meet



careful to make sure it is consistent with North Carolina law.

care agent may make any health care decision you could make yourself.

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This document gives the person you designate as your health care agent broad powers to make health care decisions for you when you cannot make the decision yourself or cannot communicate your decision to other people. You should discuss your wishes concerning life-prolonging measures, mental health treatment, and other health care decisions with your health care agent. Except to the extent that you express specific limitations or restrictions in this form, your health

certain requirements. If you prepare your own health care power of attorney, you should be very

This form does not impose a duty on your health care agent to exercise granted powers, but when a power is exercised, your health care agent will be obligated to use due care to act in your best interests and in accordance with this document.

This Health Care Power of Attorney form is intended to be valid in any jurisdiction in which it is presented, but places outside North Carolina may impose requirements that this form does not meet.

If you want to use this form, you must complete it, sign it, and have your signature witnessed by two qualified witnesses and or proved by a notary public. Follow the instructions about which choices you can initial very carefully. **Do not sign this form until** two witnesses and or a notary public are present to watch you sign it. You then should give a copy to your health care agent and to any alternates you name. You should consider filing it with the Advance Health Care Directive Registry maintained by the North Carolina Secretary of State: http://www.nclifelinks.org/ahcdr/State.

By signing here, I indicate that I am mentally alert and competent, fully informed as to the contents of this document, and understand the full import of this grant of powers to my health care agent.

This the _____ day of ______, 20____.

(SEAL)(SIGNATURE)

I hereby state that the principal, ______, being of sound mind, signed (or directed another to sign on the principal's behalf) the foregoing health care power of attorney in my presence, and that I am not related to the principal by blood or marriage, and I would not be entitled to any portion of the estate of the principal under any existing will or codicil of the principal or as an heir under the Intestate Succession Act, if the principal died on this date without a will. I also state that I am not the principal's attending physician, nor a licensed health care provider or mental health treatment provider who is (1) an employee of the principal's attending physician or mental health treatment provider, (2) an employee of the health facility in which the principal is a patient, or (3) an employee of a nursing home or any adult care home where the principal resides. I further state that I do not have any claim against the principal or the estate of the principal.

If you elect to have your declaration witnessed, complete the following section:

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Date:	Witness:		
Date:		Witness:	
	COUNTY,	STATE	
Sworn to (or affin	rmed) and subscribed be	fore me this day by _	
			(type/print name of signer)
			(type/print name of witness)
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qualified notary p			
(Offic	cial Seal)	Signatui	re of Notary Public
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ADVANCE DIRECTIVE FOR A NATURAL DEATH ("LIVING WILL")

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NOTE: YOU SHOULD USE THIS DOCUMENT TO GIVE YOUR HEALTH CARE PROVIDERS INSTRUCTIONS TO WITHHOLD OR WITHDRAW LIFE-PROLONGING MEASURES IN CERTAIN SITUATIONS. THERE IS NO LEGAL REQUIREMENT THAT ANYONE EXECUTE A LIVING WILL.

 GENERAL INSTRUCTIONS: You can use this Advance Directive ("Living Will") form to give instructions for the future if you want your health care providers to withhold or withdraw life-prolonging measures in certain situations. You should talk to your doctor about what these terms mean. The Living Will states what choices you would have made for yourself if you were able to communicate. Talk to your family members, friends, and others you trust about your choices. Also, it is a good idea to talk with professionals such as your doctors, clergypersons, and lawyers before you complete and sign this Living Will.

You do not have to use this form to give those instructions, but if you create your own Advance Directive you need to be very careful to ensure that it is consistent with North Carolina law.

This Living Will form is intended to be valid in any jurisdiction in which it is presented, but places outside North Carolina may impose requirements that this form does not meet.

If you want to use this form, you must complete it, sign it, and have your signature witnessed by two qualified witnesses and or proved by a notary public. Follow the instructions about which choices you can initial very carefully. **Do not sign this form until** two witnesses and or a notary public are present to watch you sign it. You then should consider giving a copy to your primary physician and/or a trusted relative, and should consider filing it with the Advanced Health Care Directive Registry maintained by the North Carolina Secretary of State: http://www.nclifelinks.org/ahedr/State.

My Desire for a Natural Death

being of sound mind, desire that, as specified below, my life not be prolonged by life-prolonging measures: . . . I hereby state that the declarant, ______, being of sound mind, signed (or directed another to sign on declarant's behalf) the foregoing Advance Directive for a Natural Death in my presence, and that I am not related to the declarant by blood or marriage, and I would not be entitled to any portion of the estate of the declarant under any existing will or codicil of the declarant or as an heir under the Intestate Succession Act, if the declarant died on this date without a will. I also state that I am not the declarant's attending physician, nor a licensed health care provider who is (1) an employee of the declarant's attending physician, (2) nor an employee of the health facility in which the declarant is a patient, or (3) an employee of a nursing home or any adult care home where the declarant resides. I further state that I do not have any claim against the declarant or the estate of the declarant. Box #1

If you elect to have your declaration witnessed, complete the following section:

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Witness:

Date:		Session 202	
Date	Witness:		
COUNTY,	STATE		
Sworn to (or affirmed) and subscribed l	before me this day by _		
		(type/print name of declarant)	
		(type/print name of witness)	
		(type/print name of witness)	
Box #2 If you elect to have your declaration	notarized, have the fo	ollowing section completed by	
qualified notary public:			
Date(Official Seal)		ture of Notary Public	
		, Notary Public	
	Printed	or typed name	
	My con	nmission expires:"	
PART III. ELECTRONIC FILING C ADVANCE HEALTH CARE DI		OWERS OF ATTORNET AND	
SECRETARY OF STATE			
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SECTION 3.2. G.S. 130A-468 reads as rewritten:

"§ 130A-468. Filing of documents with the registry.

- (a) When the Secretary of State receives a <u>hard copy of a document</u> that may be filed with the registry pursuant to this Article, the Secretary shall create a digital reproduction of that document and enter the reproduced document into the registry database. When the Secretary of State receives a document in electronic format that may be filed with the registry pursuant to this Article, the Secretary shall enter that document into the registry database. The Secretary is not required to review a document to ensure that it complies with the particular statutory requirements applicable to the document. Each document entered into the registry database shall be assigned a unique file number and password.
- (b) Upon entering the a reproduced hard copy of a document into the registry database, the Secretary shall return the original hard copy of the document and a wallet-size card containing the document's file number and password to the person who submitted the document. Upon entering into the registry database a document that was received in electronic format, the Secretary shall send a wallet-size card containing the document's file number and password to the person who submitted the document.
- (c) When the Secretary of State receives a revocation of a document that is filed with the registry and that document's file number and password, or a request to remove that document from the registry without its revocation, the Secretary shall delete that document from the registry database.
- (c1) The Secretary of State may remove documents of deceased registrants from the registry upon notification of death in writing in a form acceptable to the Secretary of State.
- (d) The Secretary of State's entry of a document into, or removal of a document from, the registry database does not do any of the following:
 - (1) Affect the validity of the document in whole or in part.
 - (2) Relate to the accuracy of information contained in the document.
 - (3) Create a presumption regarding the validity of the document, regarding the accuracy of information contained in the document, or that the statutory requirements for the document have been met."

PART IV. EFFECTIVE DATE

SECTION 4.1. This act becomes effective October 1, 2025.

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