Durable Power of Attorney for Healthcare Decisions

» *Take a copy of this with you whenever you go to the hospital or on a trip* «

It is important to choose someone to make healthcare decisions for you when you cannot make or communicate decisions for yourself. Tell the person you choose what healthcare treatments you want. You may write any specific instructions for what you DO or DO NOT want. The person you choose will be your agent. He or she will have the right to make decisions for your healthcare. If you DO NOT choose someone to make decisions for you write NONE on the line for the agent's name.

I, (print your name) _____, appoint the person named in this document to be my agent to make my healthcare decisions. This document is a Durable Power of Attorney for Healthcare Decisions. My agent's power shall not end if I become incapacitated or if there is uncertainty that I am dead. This document revokes any prior Durable Power of Attorney for Healthcare. My agent may not appoint anyone else to make decisions for me. My agent and caregivers are protected from any claims based on following this Durable Power of Attorney for Healthcare. My agent shall not be responsible for any costs associated with my care. I give my agent full power to make all decisions for me about my healthcare, including the power to direct the withholding or withdrawal of life-prolonging treatment, including artificially supplied nutrition and hydration/tube feeding. My agent is authorized to:

- Consent, refuse, or withdraw consent to any care, procedure, treatment, or service to diagnose, treat, or maintain a physical or mental condition, including artificial nutrition and hydration;
- Make all necessary arrangements for any hospital, psychiatric treatment facility, hospice, nursing home, or other healthcare organization; and, employ or discharge healthcare personnel (any person who is authorized or permitted by the laws of the state to provide healthcare services) as he or she shall deem necessary for my physical, mental, or emotional well-being;
- Request, receive, review and authorize sending any information regarding my physical or mental health, or my personal affairs, including medical and hospital records; and execute my releases that my be required to obtain such information;
- Move me into or out of any State or institution;
- Take legal action if needed;
- Make decisions about autopsy, tissue and organ donation, and the disposition of my body in conformity with state law; and
- Become my guardian if one is needed.

In exercising this power, I expect my agent to be guided by my directions as we discussed them prior to this appointment and/or to be guided by my Living Will.

If you DO NOT want the person (agent) you name to be able to do any of the above things, draw a line through it, and put your initials at the end of the line. You may choose to add additional instructions for what you DO or DO NOT want from your agent.

Agent's Name _____ Phone #_____

Address _____

If the above-named agent is unable or unwilling to make healthcare decisions for me, I designate the following person(s), in the order listed, to be my agent for healthcare decisions. If you do NOT want to name an alternate, write "none".

First Alternate Agent
Name _____
Address_____
Phone #_____

Second Alternate Agent
Name _____
Address_____
Phone #_____

Execution and Effective Date of Appointment

My agent's authority is effective immediately for the limited purpose of having full access to my medical records and to confer with my healthcare providers and me about my condition. My agent's authority to make all healthcare and related decisions for me is effective when and only when I cannot make my own healthcare decisions.

SIGN HERE for the *Durable Power of Attorney for Healthcare Decisions*. Many states require notarization. It is recommended for the residents of all states. If not notarized, please ask two persons to witness your signature who are not related to you or financially connected to your estate.

Signature_____ Date_____

Witness_____ Date_____ Witness_____ Date_____

NOTARIZATION:

On this _____ day of _____, in the year of _____, personally appeared before me the person signing, known by me to be the person who completed this document and acknowledged it as his/her free act and deed. IN WITNESS WHEREOF, I have set my hand and affixed my official seal in the County of _____, State of _____ on the date above written.

Notary Public_____

My Commission expires: _____