Name:____________________________

MRN:_____________________________

Date of Birth:______________________

MY POWER OF ATTORNEY FOR HEALTH CARE

THIS POWER OF ATTORNEY REVOKES ALL PREVIOUS POWERS OF ATTORNEY FOR HEALTH CARE

My name (print):____ Date of Birth:______________________

Address:____ Phone:______________________

I WANT THE FOLLOWING PERSON TO BE MY HEALTHCARE AGENT:

(An agent is your personal representative under state and federal law.)

Agent name:____

Agent phone number: Cell _________________________ Work _________________________ Home _________________________

Agent address:____

SUCCESSOR HEALTHCARE AGENT(S):

If the agent I selected is unable or does not want to make healthcare decisions for me, then I request the person(s) I name below to be my successor healthcare agent(s). Only one person at a time can serve as my agent (add another page if you want to add more successor agent names):

Successor agent #1 name:____ Phone:______________________

Address:____

Successor agent #2 name:____ Phone:______________________

Address:____

MY AGENT CAN MAKE HEALTHCARE DECISIONS FOR ME, INCLUDING:

i. Deciding to accept, withdraw, or decline treatment for any physical or mental condition of mine, including life-and-death decisions.

ii. Agreeing to admit me to or discharge me from any hospital, home, or other institution, including a mental health facility.

iii. Having complete access to my medical and mental health records, and sharing them with others as needed, including after I die.

iv. Carrying out the plans I have already made, or, if I have not done so, making decisions about my body or remains, including organ, tissue, or whole body donation, autopsy, cremation, and burial.

I AUTHORIZE MY AGENT TO:

(Select only <u>one</u> statement. If multiple or none are selected, then option 1 will be used.)

☐ 1. Make decisions for me only when I cannot make them for myself. The physician(s) taking care of me will determine when I lack this ability.

OR

☐ 2. Make decisions for me only when I cannot make them for myself. The physician(s) taking care of me will determine when I lack this ability. But starting now, for the purpose of assisting me with my healthcare plans and decisions, my agent shall have (1) complete access to my medical and mental health records, (2) the authority to share them with others as needed, and (3) the complete ability to communicate with my personal physician(s) and other healthcare providers, including the ability to require an opinion of my physician as to whether I lack the ability to make decisions for myself.

OR

☐ 3. Make decisions for me starting now and continuing after I am no longer able to make them for myself. While I am still able to make my own decisions, I can still do so if I want to. This authority includes having complete access to my medical records, authority to share my records, and communicate with my physician(s) as stated in option #2.

Check box if applicable (optional):

☐ If a guardian of my person is to be appointed, I nominate the agent acting under this power of attorney as guardian.

Name:________________________
MRN:________________________
Date of Birth:________________________

MY POWER OF ATTORNEY FOR HEALTH CARE

LIFE-SUSTAINING TREATMENTS

The subject of life-sustaining treatment is of particular importance. Life-sustaining treatments may include tube feedings or fluids through a tube, breathing machines, and CPR. In general, in making decisions concerning life-sustaining treatment, your agent is instructed to consider the relief of suffering, the quality as well as the possible extension of your life, and your previously expressed wishes. Your agent will weigh the burdens versus benefits of proposed treatments in making decisions on your behalf.

Statements concerning the withholding or removal of life-sustaining treatment are described below. These can serve as a guide for your agent when making decisions for you. Ask your physician or healthcare provider if you have any questions about these statements.

SELECT ONLY ONE STATEMENT BELOW THAT BEST EXPRESSES YOUR WISHES (OPTIONAL):

☐ The quality of my life is more important than the length of my life. If I am unconscious and my attending physician believes, in accordance with reasonable medical standards that I will not wake up or recover my ability to think, communicate with my family and friends, and experience my surroundings, I do not want treatments to prolong my life or delay my death, but I do want treatment or care to make me comfortable and to relieve me of pain.

OR

☐ Staying alive is more important to me, no matter how sick I am, how much I am suffering, the cost of procedures, or how unlikely my chances are for recovery. I want my life to be prolonged to the greatest extent possible in accordance with reasonable medical standards.

SPECIFIC LIMITATIONS TO MY AGENT'S DECISION-MAKING AUTHORITY

The above grant of power is intended to be as broad as possible so that your agent will have the authority to make any healthcare decisions on your behalf. If you wish to limit the scope of your agent's power, prescribe special rules, or limit the power to authorize an autopsy or dispose of remains, you may do so on the lines below or add another page if needed.

____

____

____

____

YOU AND A WITNESS MUST SIGN THIS FORM BEFORE IT IS VALID.

My signature:____ Today's date:__________________

WITNESS MUST AGREE TO THE FOLLOWING AND SIGN BELOW (REQUIRED):

- I am at least 18 years of age AND either I saw the principal sign this document OR the principal told me that the signature or mark on the principal signature line is his/hers. The principal is known to me and I believe him/her to be of sound mind.
- I am not the agent or successor agent(s) named in this document. I am not related to the principal, the agent, or the successor agent(s) by blood, marriage, or adoption.
- I am not the principal's physician, advanced practice registered nurse, physician assistant, dentist, podiatrist, optometrist, psychologist, or a relative of one of those individuals. I am not an owner or operator (or the relative of an owner or operator) of the healthcare facility where the principal is a patient or resident.

Witness printed name:____ Phone:__________________

Witness address:____

Witness signature:____ Today's date:__________________