Notice: This document permits another person to make important decisions for you, including the decision to withhold life-giving medical treatment. It is an outline that may or may not be valid in your jurisdiction. If you suspect abuse or neglect in a nursing home, please contact the Consumer Justice Group at 877-ABUSE AD or at www.consumerjusticegroup.com/nursinghomeabuse

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

I, _____,
[Person #1, individual granting the power]
hereby appoint the following as my primary agent to make health care decisions on my behalf as authorized herein:

Primary Agent [Person #2] _____

Telephone Number _____

Address _____

_____

E-mail Address _____

If the above named primary agent is unable or unwilling to act as my agent, then I appoint the following as my alternate agent to serve in that capacity:

Alternate Agent [Person #3] _____

Telephone Number _____

Address _____

_____

E-mail Address _____

I hereby grant to my agent the power and authority to make health care decisions on my behalf whenever I have been determined to be incapable of making an informed decision about providing, withholding or withdrawing medical treatment. The phrase "incapable of making an informed decision" means unable to understand the nature, extent and probable consequences of a proposed medical decision or unable to make a rational evaluation of the risks and benefits of a proposed medical decision as compared with the risks and benefits of alternatives to that decision or unable to communicate such understanding in any way.

My agent's authority hereunder is effective as long as I am incapable of making an informed decision. The determination that I am incapable of making an informed decision shall be made by my attending physician and a second physician or licensed clinical psychologist after a personal examination of me and shall be certified in writing. Such certification shall be required before treatment is withheld or withdrawn and before, or as soon as reasonably practicable after, treatment is provided and every 180 days thereafter while the treatment continues.

In exercising the power to make health care decisions on my behalf, my agent shall follow my desires and preferences as stated in this document or as otherwise known to my agent. My agent shall be guided by my medical diagnosis and prognosis and any information provided by my physicians as to the intrusiveness, pain, risks and side effects associated with treatment or nontreatment. My agent shall not authorize a course of treatment which he/she knows, or upon reasonable inquiry ought to know, conflicts with my beliefs or values, whether expressed orally or in writing. If my agent cannot determine what treatment choice I would have made on my own behalf, then my agent shall make a choice for me based upon what he/she believes to be in my best interests. My agent shall not be liable for the costs of treatment that he/she authorizes, unless my agent would be liable without holding this durable power.

The powers of my agent shall include the following:

[Cross through any powers below you **do not** want to give your agent. Pay special attention to the numbered portions.]

A. To consent to, or refuse or withdraw consent to, any type of medical care, treatment, surgical procedure, diagnostic procedure, medication and the use of mechanical or other procedures that affect any bodily function, including but not limited to 1. artificial respiration, 2. artificially administered nutrition (food) and hydration (water) and 3. cardiopulmonary resuscitation.

This authorization specifically includes the power to consent to the 4. administration of dosages of pain-relieving medication in excess of recommended dosages in an amount sufficient to relieve pain, even if such medication carries the risk of addiction or inadvertently hastens my death;

B. To request, receive and review any information (whether verbal, written, printed or electronically recorded) regarding my physical or mental health, including but not limited to medical, hospital and other records; and to consent to or authorize the use and disclosure of such information; and to otherwise serve as my personal representative for such purposes;

C. To employ and discharge my health care providers;

D. To authorize my admission to or discharge (including transfer to another facility) from any hospital, hospice, nursing home, assisted living facility or other medical care facility;

E. To make decisions about who may visit me, subject to physician orders and policies of any institution to which I am admitted;

F. To take any lawful actions necessary to carry out these decisions, including the granting of releases of liability to medical providers;

G. Upon my death, I direct that my agent make an anatomical gift of all of my body, or certain organ, tissue or eye donation pursuant to applicable law and in accordance with my directions.

This is the _____ day of _____, 20_____ .

_____
Signature of Principal (person #1)

_____
Signature of Witness A (NOT person #2 nor #3)

_____
Signature of Witness B (NOT person #2 nor #3)

The principal did personally appear before me and this instrument was acknowledged before me.

_____
Signature of Notary Public

Notary Public for _____

My commission expires _____ SEAL