Durable Power of Attorney for Health Care

I understand that my wishes as expressed in my Living Will may not cover all possible aspects of my care if I become incapacitated. Consequently, there may be a need for someone to accept or refuse medical interventions on my behalf, in consultation with my physicians. Therefore,

I, _____, as principal, do hereby designate and appoint the person(s) listed below as my agent(s) for health care decisions as authorized by this document. *(May not be your doctor or his/her employee, or an employee or owner of any health care facility where you are now a patient or resident.)*

First Choice:

Name _____

Address _____

City/State/Zip Code _____

Telephone _____

If the above person is unable, unavailable, or unwilling to serve, I designate:

Second Choice:

Name _____

Address _____

City/State/Zip Code _____

Telephone _____

I have discussed my desires regarding health care with the above named agent, who is aware of my opinion regarding life-sustaining treatment.

If I become incapable of giving informed consent with respect to health care decisions, I hereby grant my agent full power and authority to make health care decisions for me in consultation with attending physicians and health care personnel, after appropriate assessment and diagnosis of my condition.

The powers of my agent under this Power of Attorney are limited to making decisions about my health care on my behalf. These powers should include all access to all medical records, and the power to order the withholding or withdrawal of life-sustaining treatment if my agent believes, in his or her own judgement, that is what I would want if I could make the decision myself. The existence of this Durable Power of Attorney for Health Care shall have no effect upon the validity of any other Power of Attorney for other purposes that I have executed or may execute in the future.

CHOOSE A or B below:

A) This Power of Attorney shall take effect at once, regardless of disability, and stay in effect until I revoke it. ____ *(Initial here if this is your choice.)*

B) This Power of Attorney shall take effect upon my incapacity to make my own health care decisions, as determined by my treating physician and one other physician, and shall continue as long as that incapacity lasts or until I revoke it, whichever happens first. ____ *(Initial here if this is your choice.)*

1. I DO/DO NOT *(circle one and cross out the other)* want assisted ventilation (use of a respirator to help keep a person breathing) if I am diagnosed to be in a terminal condition or a permanent unconscious condition.

2. I DO/DO NOT *(circle one and cross out the other)* want tube feeding (use of a tube to the nose or abdomen for feeding a person who cannot take food by mouth) if I am diagnosed to be in a terminal condition or a permanent unconscious condition.

3. I DO/DO NOT *(circle one and cross out the other)* want artificial hydration (giving liquids by tube or intravenously to a person who cannot drink) if I am diagnosed to be in a terminal condition or a permanent unconscious condition.

4. I make the following additional instructions regarding my care:

_____

_____

BY SIGNING THIS DOCUMENT, I indicate that I understand the purpose and effect of this Durable Power of Attorney for Health Care.

Dated this _____ day of _____ , 20 _____

Signed: _____

Signing this form is voluntary; a health care provider may not require you to have a power of attorney. You may revoke or modify this power of attorney at any time.

Optional Witness Section

The person named as principal in this document is personally known to me. I believe that he/she has the capacity to make health care decisions, and that he/she signed this document freely and voluntarily.

Witness: _____ Date: _____

Witness: _____ Date: _____