

DURABLE POWER OF ATTORNEY FOR HEALTHCARE

IMPORTANT NOTICE

PLEASE CAREFULLY REVIEW THE FOLLOWING INFORMATION BEFORE SIGNING THIS DOCUMENT. SEEK GUIDANCE FROM A HEALTHCARE PROFESSIONAL OR ATTORNEY IF ANY TERMS ARE UNCLEAR.

By affixing your signature to this document, you grant authorization to the individual designated as your agent to make medical decisions on your behalf. These decisions encompass a wide array of medical services, treatments, procedures, diagnoses, and care for both mental and physical conditions. Your agent will possess the same authority you would have if you were capable of acting for yourself, including consenting to or declining medical treatment, including decisions concerning life-sustaining treatment. Therefore, it is crucial to select an agent whom you trust implicitly and who is fully cognizant of your healthcare preferences.

You maintain the capacity to make your own healthcare decisions as long as you are mentally competent. Your agent can only assume authority once your physician determines that you are incapable of making medical decisions.

Your chosen agent must be at least eighteen years old and someone you have complete confidence in regarding your healthcare. They bear no liability for decisions made in good faith. It is imperative to ensure that your chosen agent is willing to take on this responsibility and to have a discussion with them regarding your medical preferences. Additionally, it is advisable to consider selecting a backup agent who is also acquainted with your preferences.

You have the right to revoke this document at any time while you are competent by notifying your medical provider and agent either verbally or in writing. Executing another power of attorney will automatically revoke this one.

For this document to be considered valid, it must be signed in the presence of a notary public or two witnesses who are at least eighteen years old, mentally competent, impartial, and not related to your designated agent.

1. NAME OF PRINCIPAL

I, [Your Name], residing at [Your Address], being of sound mind and understanding the importance of planning for my future healthcare decisions, hereby declare this Durable Power of Attorney for Health Care ("Power of Attorney") effective as of [Effective Date].

2. APPOINTMENT OF AGENT

I, [PRINCIPAL'S NAME], residing at [MAILING ADDRESS], HEREBY LEGALLY APPOINT

[Agent's Name], residing at [Agent's Address], as my agent to make healthcare decisions on my behalf, including decisions regarding medical treatment, surgery, hospitalization, and other healthcare matters, in the event that I am unable to make or communicate such decisions myself. My agent's authority shall commence only if and when my attending physician determines that I lack the capacity to make healthcare decisions.

2. AGENT'S AUTHORITY

My agent is authorized to:

- I. Consent to or refuse medical treatment, including surgery, medication, and other procedures, in accordance with my wishes and best interests.
- II. Access my medical records and communicate with healthcare providers regarding my healthcare needs and preferences.
- III. Make decisions about the withdrawal or withholding of life-sustaining treatment, including artificial nutrition and hydration, if I am in a terminal condition or in a persistent vegetative state.
- IV. Make decisions about my care and treatment in accordance with any written instructions I provide in advance, including a living will or other healthcare directives.

3. AGENT LIMITATIONS AND INSTRUCTIONS

I provide the following limitations and instructions for my agent:

[DESCRIBE LIMITATIONS.]

4. SUCESSOR AGENTS

In the event that the individual appointed as my agent above cannot or chooses not to fulfill their role, I designate the following person(s) to act as agents in the sequence outlined below, granting them the authority to make healthcare decisions on my behalf as specified herein:

First Successor Agent:

Name: [AGENT'S NAME]
Address: [AGENT'S ADDRESS]
Phone: [AGENT'S PHONE]

Second Successor Agent:

Name: [AGENT'S NAME]
Address: [AGENT'S ADDRESS]
Phone: [AGENT'S PHONE]

5. DOCUMENTS LOCATION (ORIGINAL AND COPIES)

The primary document is/will be lodged at the specified location(s): [PRIMARY LOCATION OF DOCUMENTS]

I have/will furnish copies of my Durable power of attorney for Health care to the following:[LOCATION OF DOCUMENT COPIES]

6. DURATION AND REVOCATION

This Durable Power of Attorney shall remain in effect: (select one)

- **INDEFINITELY**. This power of attorney shall terminate upon my demise or written revocation.

- **TERMINATION DATE**. This power of attorney shall conclude on [DATE].

6. SEVERABILITY

If any provision of this Power of Attorney is held to be invalid or unenforceable, the remaining provisions shall remain in full force and effect.

By signing this document, I hereby revoke any and all prior Durable powers of attorney for Healthcare that I may have executed.

7. EXECUTION

I understand the nature and purpose of this Durable Power of Attorney for Health Care and execute it voluntarily, without any undue influence or coercion.

Signed this [Date] day of [Month, Year].

Principal's Signature: _____

Print Name: _____

NOTARY ACKNOWLEDGMENT

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of: _____ }

County of: _____ }

On this ____ day of _____, 20____, before me appeared _____, as Principal of this **Durable Power of Attorney for Healthcare** who proved to me through government issued photo identification to be the above-named person, in my presence executed foregoing instrument and acknowledged that (s)he executed the same as his/her free act and deed.

Notary Public: _____

Print Name: _____

My commission expires: _____

WITNESS STATEMENT AND ACKNOWLEDGMENT

I declare that I am not the individual designated as the agent or successor agent in this medical power of attorney. I affirm that I have no familial relationship, whether by blood or marriage, with the principal mentioned in this document. I confirm that I have no entitlement to any portion of the principal's estate, nor do I assert any claim against the principal's estate. Furthermore, I am not the attending physician of the principal, nor am I affiliated with the attending physician in any professional capacity. I am not directly involved in providing patient care to the principal, and I do not hold any official position as an officer, director, partner, or employee of the healthcare facility or any associated parent organization.

Witnessed by:

_____ [Witness Signature]
[Witness Name]
[Witness Address]

_____ [Witness Signature]
[Witness Name]
[Witness Address]