MEDICAL POWER OF ATTORNEY

This Medical Power of Attorney (hereinafter referred to as the "Document") is made and executed on _____.

DESIGNATION OF HEALTH CARE AGENT

I, _____, residing at _____, hereby appoint:

Name: _____
Address: _____
Phone: _____
Email: _____

as my agent (attorney-in-fact) to make any and all health care decisions for me, except to the extent I state otherwise in this document. This Medical Power of Attorney takes effect if I become unable to make my own health care decisions and this fact is certified in writing by my physician.

ALTERNATE AGENTS

FIRST ALTERNATE AGENT

If my agent is unable or unwilling to make health care decisions for me, I designate as my first alternate agent:

Name: _____
Address: _____
Phone: _____
Email: _____

AGENT'S AUTHORITY

My agent is authorized to make all health care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care to keep me alive, except as I state here:

_____

_____

_____

_____

WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE

My agent's authority becomes effective when my attending physician determines that I am unable to make my own health care decisions. I want my agent's authority to begin now, even though I am still capable of making my own decisions.

AGENT'S OBLIGATIONS

My agent shall make health care decisions for me in accordance with this power of attorney, any instructions I give in this document, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

NOMINATION OF GUARDIAN

If a guardian of my person needs to be appointed for me by a court, I nominate my agent (or alternate) named above for appointment as guardian to serve without bond or security.

HIPAA RELEASE AUTHORITY

I intend for my agent to be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. 1320d and 45 CFR 160-164, and the regulations promulgated thereunder. I authorize any physician, healthcare professional, dentist, health plan, hospital, clinic, laboratory, pharmacy, or other covered healthcare provider, any insurance company, and the Medical Information Bureau, Inc., or other healthcare clearinghouse that has provided treatment or services to me, or that has paid for or is seeking payment from me for such services, to give, disclose, and release to my agent, without restriction, all of my individually identifiable health information and medical records regarding any past, present, or future medical or mental health condition.

SPECIFIC MEDICAL DIRECTIVES

LIFE-SUSTAINING TREATMENT

If I am in a terminal condition with no hope of improvement: I direct that my agent decide about life-sustaining treatment

ARTIFICIAL NUTRITION AND HYDRATION

Regarding artificial nutrition and hydration (food and water provided by feeding tube or intravenous line): I direct that my agent decide about artificial nutrition and hydration

RELIEF FROM PAIN

I direct that treatment for alleviation of pain or discomfort be provided at all times.

OTHER WISHES

I direct the following regarding my medical care:

_____

_____

_____

_____

ORGAN DONATION

Status: I direct that my agent decide about organ donation.

For the following purposes:

Governing Law

This Medical Power of Attorney is governed by the state laws of _____.

EFFECT OF COPY

A copy of this Medical Power of Attorney has the same effect as the original.

SIGNATURE

I sign my name to this Medical Power of Attorney on _____.

Principal Signature: _____
Print Name: _____

WITNESS STATEMENT

I declare under penalty of perjury that the person who signed or acknowledged this document is personally known to me (or proved to me on the basis of satisfactory evidence) to be the principal, that the principal signed or acknowledged this Medical Power of Attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, that I am not the person appointed as agent by this document, and that I am not a health care provider, an employee of a health care provider, the operator of a community care facility, or an employee of an operator of a community care facility.

Witness #1 Signature: _____
Print Name: _____
Address: _____
Date: _____

Witness #2 Signature: _____
Print Name: _____
Address: _____
Date: _____

NOTARY ACKNOWLEDGMENT

State of _____
County of _____

On _____, before me, _____, personally appeared _____, who proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to the within instrument and acknowledged to me that they executed the same in their authorized capacity, and that by their signature on the instrument the person, or the entity upon behalf of which the person acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of _____ that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Notary Public Signature: _____

(Seal)

ACCEPTANCE BY AGENT

I accept this appointment and agree to serve as agent for health care decisions. I understand I have a duty to act consistently with the principal's desires as stated in this document or otherwise made known to me. I understand that this document gives me authority to make health care decisions for the principal only if the principal becomes incapacitated. I understand that I must act in good faith in exercising my authority under this power of attorney. I understand that the principal may revoke this power of attorney at any time in any manner.

If I choose to withdraw as agent, I must inform the principal of my decision. If the principal is not capable of understanding my withdrawal, I must inform the principal's caregivers of my withdrawal.

Agent Signature: _____
Print Name: _____
Date: _____

Alternate Agent Signature: _____
Print Name: _____
Date: _____