Medical Power of Attorney

Effective Upon Execution

I, [NAME], a resident of [ADDRESS. COUNTY, STATE]; Social Security Number [NUMBER] designate [NAME], presently residing at [ADDRESS], telephone number [PHONE NUMBER] as my agent to make any and all health care decisions for me, except to the extent I state otherwise in this document. For the purposes of this document, "health care decision" means consent, refusal of consent, or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose, or treat an individual's physical or mental condition. 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.

Limitations: [Describe any desired limitations, for example, concerning life support, life-prolonging care, treatment, services, and procedures.]

Inspection and Disclosure of Information Relating to My Physical or Mental Health: Subject to any limitations in this document, my agent has the power and authority to do all of the following:

1. Request, review, and receive any information, verbal or written, regarding my physical or mental health, including, but not limited to, medical and hospital records;

2. Execute on my behalf any releases or other documents that may be required in order to obtain this information;

3. Consent to the disclosure of this information.

Additional Powers: Where necessary to implement the health care decisions that my agent is authorized by this document to make, my agent has the power and authority to execute on my behalf all of the following:

1. Documents titled or purporting to be a "Refusal to Permit Treatment" and "Leaving Hospital Against Medical Advice";

2. Any necessary waiver or release from liability required by a hospital or physician.

Duration: This power of attorney exists indefinitely from its date of execution, unless I establish herein a shorter time or revoke the power of attorney.

[***If applicable***: This power of attorney expires on [DATE]. If I am unable to make health care decisions for myself when this power of attorney expires, the authority I have granted my agent shall continue to exist until such time as I become able to make health care decisions for myself.]

Alternative Agent: In the event that my designated agent becomes unable, unwilling, or ineligible to serve, I hereby designate [NAME], presently residing at [ADDRESS], telephone number [PHONE NUMBER] as my as my first alternate agent, and [NAME], presently residing at [ADDRESS], telephone number [PHONE NUMBER] as my as my second alternate agent.

Prior Designations Revoked: I revoke any prior Medical Power of Attorney.

Location of Documents:

The original copy of this Medical Power of Attorney is located at [Location].

Signed copies of this Medical Power of Attorney have been filed with the following individuals and institutions: [Names and Addresses].

I sign my name to this Medical Power of attorney on the date of [DATE], at [ADDRESS, COUNTY, STATE].

_____

[NAME]

Statement of Witnesses

I hereby 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 convincing evidence) to be the principal, that the principal signed or acknowledged this durable medical power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence. I am not the person appointed an agent by this document. I am not related to the principal by blood, marriage, or adoption. I would not be entitled to any portion of the principal's estate on the principal's death. I am not the attending physician of the principal or an employee of the attending physician. I have no

claim against any portion of the principal's estate on the principal's death. Furthermore, if I am an employee of a health care facility in which the principal is a patient, I am not involved in providing direct patient care to the principal and am not an officer, director, partner, or business office employee of the health care facility or of any parent organization of the health care facility.

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[WITNESS]

_____

[WITNESS]

Subscribed and sworn to before me on [DATE].

_____
Notary Public, [COUNTY, STATE]
My commission expires _____.