[YOUR NAME, ADDRESS & TELEPHONE]

DURABLE POWER OF ATTORNEY

FOR HEALTH CARE

I, [YOUR NAME], designate and appoint [NAME AND ADDRESS OF APPOINTEE], to be my agent for health care decisions and pursuant to the language stated below, on my behalf to:

A. Health Care

1. Consent, refuse consent, or withdraw consent to any care, treatment, service or procedure to maintain, diagnose, or treat a physical or mental condition, and to make decisions about organ donation, autopsy and disposition of the body;
2. Make all necessary arrangements at any hospital, psychiatric hospital, psychiatric treatment facility, hospice, nursing home, or similar institution;
3. Employ or discharge health care personnel to include physicians, psychiatrists, psychologists, dentists, nurses, therapists, or any other person who is licensed, certified, or otherwise permitted by the laws of this state to administer health care as the agent shall deem necessary for my physical, mental, and emotional well-being; and
4. Request, receive, and review any information, verbal or written, regarding my personal affairs or physical or mental health including medical and hospital records and to execute releases of other documents that may be required in order to obtain such information.

In exercising the grant of authority set forth above my agent for health care decisions shall:

 Carry out the instructions for end of life decisions as set out in my Living Will. This Power of Attorney does not extend to the revocation of my advanced directive.

The agent shall be prohibited from authorizing consent for the following items:

 None.

This durable power of attorney for health care decisions shall be subject to the additional following limitations:

 None.

The powers of the agent herein shall be limited to the extent set out in writing in this durable power of attorney for health care decisions and shall not include the power to revoke or invalidate any previously existing declaration made in accordance with the natural death act.

I hereby knowingly and purposefully waive any and all rights I may now have and in the future under the Health Insurance Portability and Accountability Act (HIPAA), Public Law 104-191, and the Department of Health and Human Services (HHS) Privacy Rule of 2000 (Standards for Privacy of Individually Identifiable Health Information) and thereby allow my doctors and all other health care providers, health care plans and clearinghouses, including the medical staff and short term medical facilities, to release all information regarding my medical history, status, diagnosis and treatment to my attorney and agent herein setout.

I understand the full import of this grant of power, and I am emotionally and mentally competent to make this decision.

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I believe the above declarant to be of sound mind. I did not sign the declarant’s signature above for or at the direction of the declarant. I am at least eighteen (18) years of age and am not related to the declarant by blood or marriage, entitled to any portion of the estate of the declarant according to the laws of intestate succession of this state or under any will of the declarant or codicil thereto, or directly financially responsible for declarant’s medical care. I am not the declarant’s attending physician.

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SUBSCRIBED AND SWORN TO BEFORE ME this day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20 .

Notary Public