Durable Power of Attorney for Healthcare Decisions

■ ***Take a copy of this with you whenever you go to the hospital or on a trip*** ■

It is important to choose someone to make healthcare decisions for you when you cannot make or communicate decisions for yourself. Tell the person you choose what healthcare treatments you want. The person you choose will be your agent. He or she will have the right to make decisions for your healthcare. If you DO NOT choose someone to make decisions for you, write NONE on the line for the agent's name.

I, _____, SS#_____ (optional, last 4 digits), appoint the person named in this document to be my agent to make my healthcare decisions.

This document is a Durable Power of Attorney for Healthcare Decisions. My agent's power shall not end if I become incapacitated or if there is uncertainty that I am dead. This document revokes any prior Durable Power of Attorney for Healthcare Decisions. My agent may not appoint anyone else to make decisions for me. My agent and caregivers are protected from any claims based on following this Durable Power of Attorney for Healthcare. My agent shall not be responsible for any costs associated with my care. I give my agent full power to make all decisions for me about my healthcare, including the power to direct the withholding or withdrawal of life-prolonging treatment, including artificially supplied nutrition and hydration/tube feeding. My agent is authorized to

- Consent, refuse, or withdraw consent to any care, procedure, treatment, or service to diagnose, treat, or maintain a physical or mental condition, including artificial nutrition and hydration;
- Permit, refuse, or withdraw permission to participate in federally regulated research related to my condition or disorder
- Make all necessary arrangements for any hospital, psychiatric treatment facility, hospice, nursing home, or other healthcare organization; and, employ or discharge healthcare personnel (any person who is authorized or permitted by the laws of the state to provide healthcare services) as he or she shall deem necessary for my physical, mental, or emotional well -being;
- Request, receive, review, and authorize sending any information regarding my physical or mental health, or my personal affairs, including medical and hospital records; and execute any releases that may be required to obtain such information;
- Move me into or out of any State or institution;
- Take legal action, if needed;
- Make decisions about autopsy, tissue and organ donation, and the disposition of my body in conformity with state law; and
- Become my guardian if one is needed.

In exercising this power, I expect my agent to be guided by my directions as we discussed them prior to this appointment and/or to be guided by my Healthcare Directive *(see reverse side)*.

If you DO NOT want the person (agent) you name to be able to do one or other of the above things, draw a line through the statement and put your initials at the end of the line.

Agent's name _____ Phone _____ Email_____

Address_____

*If you do **not** want to name an alternate, write "none."*

Alternate Agent's name _____ Phone _____ Email_____

Address_____

Execution and Effective Date of Appointment

My agent's authority is effective immediately for the limited purpose of having full access to my medical records and to confer with my healthcare providers and me about my condition. My agent's authority to make all healthcare and related decisions for me is effective when and only when I cannot make my own healthcare decisions.

SIGN HERE for the *Durable Power of Attorney* and/or *Healthcare Directive* forms. Many states require notarization. It is recommended for the residents of all states. Please ask two persons to witness your signature who are not related to you or financially connected to your estate.

Signature _____ Date_____

Witness_____ Date _____ Witness_____ Date_____

Notarization:

On this _____ day of_____ , in the year of _____, personally appeared before me the person signing, known by me to be the person who completed this document and acknowledged it as his/her free act and deed. IN WITNESS WHEREOF, I have set my hand and affixed my official seal in the County of_____ , State of _____, on the date written above.

Notary Public_____

Commission Expires_____

Healthcare Treatment Directive

■ *If you only want to name a Durable Power of Attorney for Healthcare Decisions, draw a large X through this page.* ■

I, _____ , SS# _____ want everyone who cares for me to know what healthcare I want.
(optional, last 4 digits)

I always expect to be given care and treatment for pain or discomfort even if such care may affect how I sleep, eat, or breathe.

I would consent to, and want my agent to consider my participation in federally regulated research related to my disorder or condition.

I want my doctor to try treatments/interventions on a time-limited basis when the goal is to restore my health or help me experience a life in a way consistent with my values and wishes. I want such treatments/interventions withdrawn when they cannot achieve this goal or become too burdensome to me.

I want my dying to be as natural as possible. Therefore, I direct that no treatment (including food or water by tube) be given just to keep my body functioning when I have

- a condition that will cause me to die soon, or
- a condition so bad (including substantial brain damage or brain disease) that I have no reasonable hope of achieving a quality of life that is acceptable to me.

An acceptable quality of life to me is one that includes the following capacities and values. (Describe here the things that are most important to you when you are making decisions to choose or refuse life-sustaining treatments.)

_____

_____

_____

_____.

Examples:
- recognize family or friends
- make decisions
- communicate
- feed myself
- take care of myself
- be responsive to my environment

If you do not agree with one or other of the above statements, draw a line through the statement and put your initials at the end of the line.

In facing the end of my life, I expect my agent (if I have one) and my caregivers to honor my wishes, values, and directives.

For further clarification, please refer to my *Caring Conversations* Workbook, which is located at _____.

Be sure to sign the reverse side of this page even if you do not wish to appoint a Durable Power of Attorney for Healthcare Decisions

Talk about this form and your ideas about your healthcare with the person you have chosen to make decisions for you, your doctors, family, friends, and clergy. Give each of them a completed copy.

You may cancel or change this form at any time. You should review it often. Each time you review it, put your initials and the date here. _____

This document is provided as a service by the Center for Practical Bioethics.
For more information, call the Center for Practical Bioethics at 816-221-1100
Email – *center@practicalbioethics.org* • Website – *www.practicalbioethics.org*