Tennessee Durable Power of Attorney for Healthcare

This is a legal document. If you do not understand it, seek the advice of an attorney.

I, _____, of (address) _____, hereby give these advance instructions on how I want to be treated by my doctors and other health care providers.

Agent: I want the following person to make health care decisions for me:

_____.

Phone number_____

If my agent is unable or unwilling, I nominate: _____

Phone number_____

Instructions: I REVOKE ANY HEALTHCARE POWER OF ATTORNEY that I have made in the past. My agent's power is effective immediately and shall not be revoked by my incapacity. My agent may look at my medical records at any time, receive copies of any records, make and schedule appointments, sign my name for me, take and give any information by phone or other means, or make decisions for me when I can't. Agent may make **funeral plans** for me and be the informant on any death certificate recorded. The only power that is reserved for my incapacity is the power to make medical decisions. My agent has the power to visit me in a hospital and shall not be turned away from visiting me by any healthcare provider

HIPAA RELEASE:

I intend for my agent to be treated the same 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 USC 1320d and 45 CFR 160-164. I authorize any physician, health-care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy or other covered health-care provider, any insurance company and the Medical Information Bureau Inc. or other health-care 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, including all information relating to the diagnosis and treatment of HIV/AIDS, sexually transmitted diseases, mental illness, and drug or alcohol abuse. The authority given to my agent has no expiration date and shall expire only if I revoke the authority in writing and deliver it to my healthcare provider.

_____
Patient Signature

STATE OF TENNESSEE

COUNTY OF _____

The person who signed this instrument is personally known to me (or proved to me based on satisfactory evidence) to be the person who signed as the "patient" and personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

_____Date_____

_____
Signature of Notary Public Commission Expires