MEDICAL DURABLE POWER OF ATTORNEY HEALTH CARE

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 health care decisions for you when you cannot. Tell the person (agent) you choose what you would want. The person you choose has the responsibility to make sure your wishes are honored and has the legal right to do so. If you DO NOT choose someone to make decisions for you, write NONE on the line for the agent's name.

I, _____, appoint the person named below to be my agent to make health care decisions for me when and only when I cannot make decisions or communicate what I want done.

This document is a Medical Durable Power of Attorney and the power of my agent shall begin when I lack capacity to make health care decisions for myself. This completed document also revokes and prior Medical Power of Attorney. My agent may not appoint anyone else to make decisions for me. Furthermore, I and my estate hold my agent and my caregivers harmless and protect them against any claim based upon following this Medical Durable Power of Attorney. (Any costs incurred should be paid from my own recourses.) Moreover, I grant to my agent full power to make all decisions for me about my health care, including the power to direct the withholding or withdrawal of life- prolonging treatment (which includes artificially supplied food and water administered by surgical procedures or IVs)> My agent is also authorized to:

- Consent, refuse or withdraw consent to any care, treatment, service or procedure used to maintain, diagnose or treat a physical or mental condition;
- Make all necessary arrangements for any hospital psychiatric treatment facility, hospice, nursing home or other health care organization; employ or discharge health care personnel (any person who is authorized or permitted by the laws of the state to provide health care services) as my agent shall deem necessary for my physical, mental or emotional well-being;
- Request, receive, and review any information regarding my physical or mental health and/or my personal affairs, including medical and hospital records; execute any releases of other documents that may be required to obtain such information;
- Move me into or out of any state or institution for the purpose of complying with my Health Care directive or the decisions of my agent
- Take legal action, if needed, to do what I have directed
- Make decisions about autopsy, organ donation and the disposition of my body in conformity with state law;

In exercising this power, I expect my agent to be guided by my direction as were discussed prior to this appointment and/or stated in my Health Care Directive (see reverse side).

If you DO NOT want the person (agent) you named to be able to do any of the above things, draw a line through it and put your initials at the end of the line.

Agent's name_____Phone_____

Agents E-mail_____

Agents Address_____

_____

Signature (optional)_____

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

First Alternate Agent_____ Second Alternate Agent_____

First Alternate Address_____ Second Alternate Address_____

_____ _____

Phone_____ Phone_____

Email_____ Email_____

SIGN HERE for the *Medical Durable Power of Attorney* and/or *Health Care Directive* forms. Many states require notarization, though it is recommended for residents of all states. Please ask two (2) persons to witness your signature who are not related or financially connected to you or your estate.

Person's name (print) _____ Signature_____

Consent of parent/guardian for minor child_____Date_____

Witness_____Date_____

Witness_____Date_____

Notarization: On this _____ day of_____, in the year of _____, personally appeared before me the person(s) signing, known by me to be the person(s) who completed this document and acknowledged it as his/her (their) free act(s) and deed(s). 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_____

HEALTH CARE DIRECTIVE

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

I,_____, want everyone who cares for me to know what health care treatments I want when I cannot let others know what I want.

I always expect to be given care and treatment for pain or discomfort. I also want my doctor to try treatments that may get me back to an acceptable quality of life. By acceptable quality of life, I mean living in a way that lets me do the things that are important and necessary to me. Those things are:

_____

_____

_____

Examples could include any, all or a combination of the following:
The ability to:

1. Live independently; 2. Be ambulatory; 3. Recognize family or friends; 4. Make decisions; 5. Communicate; 6. Feed myself; 7. Take care of myself.

END of LIFE is often portrayed as having a condition that will cause a person to die soon; it is also understood to include one who has a condition so bad that there is no reasonable hope that the individual will regain an acceptable quality of life (as described above).

Concerning my **END-of-LIFE** care, I understand that I may be given medicines to relieve pain or other symptoms. I also want to have a natural death. I **do not want my dying prolonged** with the use of artificial means (including food and water administered by surgical procedures or IVs). I want to be kept as comfortable as possible.

These are my wishes for end-of-life care._____*Initials*

If **these do not reflect your end-of-life care wishes, please communicate what your wishes are to your physician(s) and family verbally and write them in the spaces provided below.**

Clarifying/additional things I would like my family and physician to know about my end-of-life care._____

_____

_____

_____

My other directions include:_____

_____

_____

Examples could include any, all *or a combination of the following:*

- Death at home, if possible
- Donation of organs and/or tissues
- Hospice care

I expect my agent, family and health care providers to honor my wishes for end-of-life care._____*Initials*

Be sure to sign the form on the reverse side of this page.

If you only want to name a Medical Durable Power of Attorney, draw a large "X" through this page.

Talk about this form and your ideas about your health care with the person you have chosen to make decisions for you. Moreover, discuss the document and those same ideas with your doctor(s), family, friends, clergy, attorney and any other persons who might also play a role in your end-of-life care. Furthermore, be certain to give each of those individuals a completed copy. Finally, you may cancel or change this form at any time; you should also review it every so often. However, each time you review it, put your initials and date here:_____

This document is provided as a service by AdventHealth

For more information, call the Spiritual Wellness department at 913-676-2304

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